General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 38 Princess Street, KNUTSFORD, Cheshire, WA16 6BN

Pharmacy reference: 1089908

Type of pharmacy: Community

Date of inspection: 30/05/2024

Pharmacy context

This is a high street pharmacy in the town of Knutsford in Cheshire. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs to help people take their medicines properly. And it dispenses medicines as part of a substance misuse service. It provides an NHS coronavirus (COVID-19) and seasonal flu vaccination service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures relevant to its services to help team members work safely. Team members keep people's confidential information secure, and they help protect the welfare of vulnerable people using the pharmacy's services. Team members mostly keep accurate records needed by law. And they confidently help people resolve concerns in a helpful and supportive way. They record and discuss mistakes they make to learn from them and reduce the risk of future similar mistakes.

Inspector's evidence

The pharmacy had a set of current electronically held standard operating procedures (SOPs) relevant to its services. These included for dispensing, Responsible Pharmacist (RP) regulations and the sale of over-the-counter medicines. The SOPs seen were due for review in July 2024. Some team members confirmed reading the SOPs but did not recall signing a training record or the like to confirm completion. Team members were seen following procedures, such as signing dispensed by and checked by boxes on dispensing labels.

The pharmacy used a paper record for team members to record near miss errors, with regular entries made each month. These errors were identified before people received their medicines. The pharmacist and accuracy checking dispenser asked the team member involved to correct the mistake, so they could reflect on what had happened. The entries on the near miss record highlighted what had gone wrong and documented some simple reasons as to why the mistake had happened. The pharmacy used stickers on the dispensary shelves to highlight to take care with the selection of some medicines, such as propranolol and procyclidine. And stock of methotrexate was stored in a red basket on the shelf to help draw attention to take care when dispensing. A team member described how after near miss errors with pregabalin and gabapentin, they repeated what was written on the prescription as they selected the item on the shelves to reduce the risk of a further mistake. The team discussed errors as they happened, but there was no formal review at team huddles to help identify trends. A team member described the process to manage dispensing incidents. These were errors identified after a person received their medicine. But the team was unaware of how to access previous incidents and whether these were shared with the superintendent's team.

The correct RP notice was displayed. The pharmacy had a SOP relating to roles and responsibilities within the team. And the supervisor allocated tasks according to role. They were an accuracy checking dispenser and they described the process they followed to ensure all prescriptions they checked were clinically checked by the pharmacist. There was a SOP relating to complaints management. Team members were confident helping people to resolve issues and complaints and they knew when it was necessary to escalate to the pharmacist manager. They described how they listened to people's concerns and explained to people how they could help. A team member was observed listening to a concern, finding out the details of what happened and resolving the issue efficiently. The team was aware of a complaints number for head office, and there was a notice displayed with the details on for them to use.

The pharmacy had current professional indemnity insurance. Records required by law were in the main completed correctly. There were some minor omissions, such as prescriber's details were either missing or incomplete in the electronic private prescription records. The importance of making accurate records

of the prescriber whilst dispensing was discussed. From the sample checked the CD registers were up to date and complete, with checks of the physical stock against the register balance recorded monthly. For two CDs checked, the physical stock was correct against the register balance. The electronic RP record was completed correctly from the sample of entries checked.

Team members understood the importance of keeping people's personal information safe and they shredded confidential waste onsite. There was a notice displayed, signposting people to access the pharmacy's privacy policy on the company's website. The pharmacist had completed level 2 safeguarding training and team members had a good understanding of what to look out for to help protect vulnerable people. A member of the team had recently discussed some concerns they had about a vulnerable person with the GP, and this had resulted in the NHS safeguarding process being followed by the GP. There was a safeguarding process and safeguarding contact details displayed on the wall for the team to refer to if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with appropriate training and skills to deliver its services safely and effectively. Team members work well together to manage the workload. They have opportunities to complete ongoing learning to help keep their knowledge up to date. And they feel comfortable raising ideas within the team to improve the way they work.

Inspector's evidence

The RP was an employed relief manager, who was covering as the regular pharmacist manager was on leave. They were supported by an accuracy checking dispenser, who was a newly appointed supervisor and four dispensers. There were also another three employed members of the team, including two medicine counter assistants (MCA) not working at the time of inspection. The company had recently closed a nearby local branch, resulting in additional team members and additional workload being transferred. The team had seen additional footfall into the pharmacy, and they described how sometimes this meant additional pressure on the team, particularly at times when there was no dedicated MCA working, as on the day of the inspection. The dispenser covering the workload at the medicines counter was organised, polite and responded to people's queries and requests promptly and competently. The supervisor supported the pharmacist manager to ensure there was enough staff working to complete the workload and they helped allocate tasks to the team. There were some opportunities for part-time members to cover annual leave and the pharmacy limited planned annual leave to one person at a time to help ensure there was enough cover. The supervisor had the option to contact the area co-ordinator for staffing support if needed. The pharmacy was busy during the inspection, and the team was working well together in an organised way to manage the workload. There was a delivery driver, who had worked at the pharmacy for many years, and they competently described how they organised and completed the delivery of medicines.

The pharmacy team had access to ongoing training, including videos on the company's intranet and team members kept their knowledge up to date reading bulletins and information sent from head office. The supervisor helped ensure all team members completed mandatory training such as SOPs. Team members had recently completed a training module about oral health in children. They felt at ease discussing concerns they may have with the supervisor and pharmacist manager. There was also an area co-ordinator who they described as approachable should they want to speak with someone who didn't work in the pharmacy. The team held informal, ad-hoc huddles and a team member described these as a good opportunity to discuss ideas to improve the way the team worked. They gave an example of how a simple change had been adopted and made it easier for the team to locate repeat dispensing prescriptions in a file.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitably clean, hygienic, and secure. They provide an appropriately professional environment for healthcare services. Team members use a suitably sized, private consultation room for services.

Inspector's evidence

The pharmacy had a relatively large retail area, with seating for people waiting. There were two computers on the medicines counter, with the patient medication record (PMR) system on them. Team members accessed the records to help people with queries and to access information about their prescriptions. The screens were positioned to help ensure people in the retail area couldn't view the information on the screen. There was a retractable belt barrier, to prevent people from accessing medicines behind the counter and although it was not in use during the inspection, the layout of the area meant people did not attempt to access behind the counter.

The pharmacy, including the dispensary, was sufficiently well lit and kept at a reasonable temperature for working and storing medicines. There was enough bench space and shelving and a separate, good-sized area for managing the multi-compartment compliance pack dispensing service. The staff facilities were clean, with hot and cold running water and other hand washing facilities. The pharmacy was hygienic and well maintained. One area of the dispensary was a little cluttered due to full pharmaceutical waste bins being stored. And the floor of the dispensary could have been tidier, with a simple vacuum clean. The walkways were kept clear. There was a separate storage area, which was kept tidy and accessed down some stairs using a handrail for safety.

The consultation room was soundproof and of a decent size. The layout meant team members and people accessing services could sit opposite each other during a consultation. Sharps bins were stored on the side team members sat to protect people's safety. Access to the room was just off the retail area and dispensary, however there was minimal risk of unauthorised access of people's information whilst entering the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

People easily access the pharmacy's services. And the pharmacy manages and delivers these services safely. It uses an offsite pharmacy hub to help manage its dispensing workload effectively. Team members obtain medicines from recognised sources. And they appropriately store and manage these medicines, so they are suitable for people to take. They conduct regular checks to make sure medicines are fit for purpose.

Inspector's evidence

The pharmacy had a level access from the pavement outside, to help people with reduced mobility. It displayed posters and leaflets on health matters and about services provided in the pharmacy and locally. There was a poster advertising the NHS Pharmacy First service on the entrance door. The pharmacy provided a busy delivery service, and deliveries to people's homes were completed by a long-standing member of staff. The driver fully explained the delivery process including how the delivery sheet was printed in the order the deliveries were made to help with safety and efficiency. Signatures were obtained for deliveries, including for controlled drugs. Some medicines were posted through letterboxes with people's consent and the delivery driver was aware of the risks and explained how this was done only when people were bed bound and it would be more dangerous for them to come to the door. The team used fridge stickers and the driver separated medicines requiring cold storage into a polystyrene cool box to help keep these cool whilst delivering. If people were not at home medicines were returned to a dedicated shelf in delivery area of the dispensary to be checked by the team.

Team members used risk reduction measures to help them dispense safely. This included using baskets, to keep people's medicines and prescriptions together and reduce the risk of error. And a second team member double checked the volume in the measuring cylinder for substance misuse medicines to ensure people received the right quantity. These medicines were dispensed when people arrived at the pharmacy to collect them. There were different areas of the dispensary for dispensing and checking prescriptions, and dispensing into multi-compartment compliance packs was done in a room to the rear of the premises where there were less distractions from the busy pharmacy environment. The pharmacy used a hub pharmacy, that utilised automation, owned by the same company to dispense a proportion of its prescriptions. The process in the pharmacy appeared organised with prescriptions kept separate in case of queries and items to be dispensed in the pharmacy rather than at the hub pharmacy clearly highlighted. The pharmacist clinically checked prescriptions before sending the prescription data to the hub pharmacy for the prescription to be assembled. A team member demonstrated the cancellation of a prescription, and showed how this would no longer be processed at the hub. This helped prevent duplication of dispensing. Medicines arrived back from the hub in sealed bags, labelled with people's names and addresses. And team members completed a series of checks using barcode technology. They scanned a barcode on the outer container and then matched up the prescriptions with the medicine bags inside. This meant there was an audit trail of the prescriptions that had been received back.

The pharmacy used the hub pharmacy to assemble most of its compliance packs. The pharmacy kept the responsibility for the management of the service. This included the ordering and checking of prescriptions for accuracy and the clinical check by the pharmacist. There was an organised and logical process for tracking the prescriptions through the process, which was colour co-coordinated. This

meant it was easy for team members to check at what stage the dispensing was at, and how many packs had been supplied to an individual person and when. On receipt of the packs into the pharmacy, a team member completed a further check to make sure the right number of medicines were in the right compartments in the packs. The pharmacy kept a written record sheet, which detailed the person's current medicines and the time of day they took them. This was used in the dispensing and checking of medicines dispensed locally. Team members signed and dated when there were changes with people's medicines and they kept hospital discharge notes for reference. They wrote a description of what medicines looked like on the packs, so people could identify the individual medicines in the pack. The team supplied patient information leaflets for new medicines, rather than regularly each month. This was discussed during the inspection, particularly for the couple of people receiving valproate in their packs. The team member was aware of the requirement to dispense valproate in the original manufacturer's pack and had assessed the risks of dispensing into the packs. But this had not been documented. The team had other resources for dispensing valproate such as warning stickers and patient cards. There was a poster displayed in the dispensary to remind the team the requirements of valproate dispensing.

The pharmacy obtained medicines from recognised wholesalers. Pharmacy-only (P) medicines were displayed behind the pharmacy counter, to help the pharmacist supervise sales and the positioning of the pharmacist's checking bench helped support this. There was a SOP relating to the process for checking expiry dates of medicines. Copies of a date checking matrix were displayed on the wall and held online. These were up to date and initialled and dated when complete. One out-of-date medicine, which expired in June 2023, was found from a sample checked and it was removed from the shelf. And the pharmacy used short-dated stickers to highlight medicines close to their expiry date. There were two medical fridges, both with records completed daily and showing temperatures to be within the required range. Both fridges showed correct temperatures during the inspection. The pharmacy team printed a copy of medicine recalls it received by email and signed and dated the sheet with the action taken. Recently actioned recall sheets were seen stored in a file.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment for the services it provides. And the team mainly uses its equipment and facilities in ways to keep people's confidential information safe.

Inspector's evidence

The pharmacy team had reference resources and access to the internet and company's intranet for up-to-date information. It had equipment available for the services provided which included a large range of glass measures for liquids and disposable consumables for the dispensing of medicines in compliance packs. These were suitably stored. There was a blood pressure monitor, which appeared in good condition although there was no date available for it to be replaced or calibrated.

Password-protected computers and screens showing confidential information were positioned away from unauthorised view, including the monitors on the medicine counter. The pharmacy used NHS Smart cards to limit access to people's PMRs and summary care records (SCR). But the pharmacist manager's NHS Smart card was in one of the terminals even though they were on annual leave that week. This was highlighted to a team member to remove. Team members had the use of a cordless telephone to help ensure their conversations with people were held in private. Medicines awaiting collection were stored in an area just off the dispensary, and in a way that people's confidential information was not on public view.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.