General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Ansdell Medical Centre, Albany Road, LYTHAM ST. ANNES, Lancashire, FY8 4GW

Pharmacy reference: 1090834

Type of pharmacy: Community

Date of inspection: 06/08/2019

Pharmacy context

This is a community pharmacy inside a medical centre. It is situated in a residential area of Lytham St Annes, on the Fylde coast. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides services such as seasonal flu vaccinations. A number of people receive their medicines in multi-compartment compliance aids.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. People who work in the pharmacy receive training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe. But they do not always record things that go wrong, so they may miss some learning opportunities. And there may be a risk of similar mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were issued in July 2018 and their stated date of review was July 2020. The pharmacy team had signed to say they had read and accepted the SOPs. They had also completed an assessment in June 2019 to check their understanding of the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved the incorrect supply of rivaroxaban 20mg tablets instead of rosuvastatin 20mg tablets. The pharmacist investigated the error and informed the staff about it. Near miss errors were recorded on a paper log, but the pharmacist said a number of incidents had not been recorded during his absence. The pharmacist said he would review the records each month, but this had not been completed in June or July. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. There were general action points written in previous reviews, such as asking staff to take extra care whilst dispensing and to follow company procedures. The company shared learning between pharmacies by putting information on the intranet. Amongst other topics they covered common errors. The pharmacy team would discuss the information when it was received. A sign was displayed to remind staff to take care whilst dispensing "look alike, sound alike" medicines.

Roles and responsibilities of the pharmacy team were documented on a matrix. The dispenser was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. This was described in the practice leaflet which advised people they could give feedback to members of the pharmacy team. Complaints were recorded to be followed up by the pharmacist manager or the head office.

A current certificate of professional indemnity insurance for the company was seen prior to the inspection. Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly. The balance of morphine 5mg MR tablets and Concerta XL 18mg tablets were checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. Members of the pharmacy team had read the policy and signed confidentiality agreements. When questioned, the dispenser was able to correctly

describe how confidential information was segregated to be removed by the head office for destruction. A notice was on display at the medicines counter to inform people about where to find the company's privacy notice.

Safeguarding procedures were part of the SOPs and had been read by the pharmacy team. The pharmacist and technician said they had completed level 2 safeguarding training. Contact details of the local safeguarding board were in the consultation room. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. The pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, an accuracy checking technician (ACT), two trainee pharmacy technicians, two dispensers and a driver. The pharmacy team were appropriately trained or on accredited training programmes.

The normal staffing level was a pharmacist, an ACT, two staff in the dispensary and one member of staff covering the medicines counter. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. The pharmacy also used locum dispensers to provide additional cover, but staff said they were not often required.

The company provided the pharmacy team with some additional training, for example a dementia friends training pack. But further learning was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the head office. The dispenser said he received a good level of support from the pharmacist and felt able to ask for further help if he needed it.

Appraisals were conducted by the pharmacy manager. A dispenser said he felt that the appraisal process was a good chance to receive feedback about his work. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were targets for services such as MURs and NMS. But the pharmacist said he did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy appeared adequately maintained. But it was cluttered as a number of baskets had to be stored on the floor due to the limited workspace. This could cause damage to the medicines or present a tripping hazard for staff. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. The temperature was controlled by the use of electric heaters and fans. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy team does not always identify people who receive higher risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a medical centre and was suitable for wheelchair users. There was wheelchair access to the consultation room. Practice leaflets gave information about the services offered and the hours of opening. Pharmacy staff were able to list and explain the services provided by the pharmacy. A range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded in a carbon copy book for individual patients and a separate signature was obtained to confirm receipt.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 CDs were highlighted so that staff could check prescription validity at the time of supply, however; schedule 4 CDs were not. So there was a risk that these medicines could be supplied after the prescription had expired. High risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he would speak to patients to check the supply was suitable but said there were currently no relevant patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought,

and previous records were retained for future reference. Most of the compliance aids were dispensed off site at the company's hub. Consent was not obtained from the patient for medicines to be dispensed off site. So people may not be aware that their information is being shared in this way. The prescription was labelled electronically by a member of the pharmacy team. This was then checked by the pharmacist to confirm it was clinically appropriate and labelled accurately – which was auditable to indicate when this was completed and by whom. The medicines were dispensed into disposable equipment, with the address of dispensing, medication description and a dispensing check audit trail. Patient information leaflets (PILs) were not routinely supplied. So people may not have all of the information they need to take the medicines safely.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a 12-week month rotating cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker. Liquid medication did not always have the date of opening written on, including morphine sulphate oral solution which expired 3 months after opening. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received electronically by email. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources.

All electrical equipment appeared to be in working order. There were no stickers attached to indicate they had been PAT tested. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.