General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Co-Chem Pharmacy, 136 Heathfield Road, Handsworth, BIRMINGHAM, West Midlands, B19 1HJ

Pharmacy reference: 1091039

Type of pharmacy: Community

Date of inspection: 23/10/2023

Pharmacy context

This community pharmacy is on a main road in the Handsworth area of Birmingham. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it provides some other NHS funded services, such as COVID and flu vaccinations. The pharmacy team dispenses medicines into multi-compartment compliance packs for people to help make sure they remember to take them.

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 generally manages the risks associated with its services to make sure people receive appropriate care. It has written procedures, but these are not up to date, so team members may not always work effectively. They discuss their mistakes so that they can learn from them. And the team members understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the activities of the pharmacy and the services provided. The SOPs were reviewed by the Superintendent (SI) and dated to show when this review had last been completed and when it was due. They were due for review in March 2022, but this had not been done yet. Signature sheets were used to record staff training and roles and responsibilities were highlighted within the SOPs. One member of the team had not signed the SOPs, however, she said that she had read the ones that were relevant to the tasks that she was undertaking and had overlooked the signature sheets.

The SI and the pharmacy team had reviewed the pharmacy's systems as part of a reactive review after a dispensing incident and had invested in new computer system for the team to use. This new system had inbuilt safety features that reduced the chances of human error, and a dispensing assistant explained the patient safety benefits. The system had been installed onto the pharmacy's computers and the team were due to start using it at the start of next month. Training sessions had been planned and a trainer from the system provider was coming to the pharmacy to do face-to-face training. The new system required the pharmacy team to work in a very different way to how they currently did. The SI was due to review and update the current SOPs, and incorporate some SOPs provided by the system provider, so that they reflected the new working practices.

Near misses were discussed with the dispenser involved to ensure they learnt from the mistake. Dispensers corrected their own near misses to promote reflection, and they were recorded on the patient medication record (PMR) on the pharmacy's computer. Near misses were not routinely analysed for patterns or trends so additional learning opportunities could be missed. There was an SOP for dealing with dispensing errors and pharmacy incidents. But these SOPs were not being followed as the pharmacy team had developed a different process instead. Pharmacy incidents were recorded using a function on the pharmacy computer and a previous incident and the action taken following the incident was discussed.

The pharmacy offered a COVID vaccination service and a flu vaccination service. These services were primarily run by a GMC registered doctor who worked at the pharmacy for a few days each week. The team members explained that COVID vaccinations were administered using a patient specific direction (PSD) but they were unsure about the flu vaccinations. The team did not have any documents readily available to demonstrate which members of the team were authorised to administer flu vaccinations and what legal authority they were being administered under. The SI and doctor agreed to look into this and a link to flu vaccination information from Community Pharmacy England (CPE) was supplied to the SI after the inspection.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how she managed requests for codeine containing medicines.

People could give feedback to the pharmacy team in several different ways; verbal, written and by email. The pharmacy team tried to resolve issues that were within their control and would involve one of the senior members of the pharmacy team if they could not reach a solution. An example of a complaint was discussed, and the SI had sought external advice from the National Pharmacy Association (NPA) on how to address the complaint.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and two random balance checks matched the balances recorded in the register. Private prescriptions were rarely dispensed, and the records complied with requirements.

Confidential waste was stored separately from general waste and destroyed securely. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The pharmacy was registered with the Information Commissioner's Office (ICO). The SI had completed training on safeguarding. The pharmacy team understood what safeguarding meant and a dispensing assistant gave examples of types of concerns that had come across and what action the pharmacy team had taken. Safeguarding referrals were recorded on the PMR.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so the pharmacy has enough cover to provide the services. The team works well together in a supportive environment, and team members can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the SI, two qualified dispensing assistants and a level three apprentice. The SI worked as the regular RP. A GMC registered doctor worked part-time at the pharmacy and delivered some of the pharmacy's clinical services.

Annual leave was requested in advance and the team had agreed a maximum number of staff who could be off at any one time. A dispensing assistant worked flexible hours and covered absences when required. Changes to the rota were made in advance when people were on holiday and the pharmacy team adjusted their working patterns to cover each other. The pharmacy was a family-run business. Several members of the pharmacy team sometimes worked additional hours and carried out extra duties to ensure the pharmacy ran smoothly. The SI reported that he was comfortable with the current staffing levels.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. The pharmacy staff said that they could raise any concerns or suggestions with the SI and felt that he was responsive to feedback and supportive. Team members said that they would speak to other members of the team, their college tutor, or GPhC if they ever felt unable to raise an issue internally. The SI was observed making himself available throughout the inspection to discuss queries with people and giving advice when he handed out prescriptions, or with people on the telephone. Targets for professional services were not set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has consultation rooms, so that people can speak to the pharmacist in private when needed.

Inspector's evidence

The premises were appropriately equipped and well maintained. Any maintenance issues were reported to the SI and various maintenance contracts were in place. The dispensary was a good size for the services provided and an efficient workflow was in place.

Dispensing and checking activities took place on separate areas of the worktops and there was ample space to store completed prescriptions. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter. There were a small number of pharmacy medicines on the shelves in the shop. These were removed during the inspection as they had been put there in error.

The dispensary was clean and tidy. The pharmacy was cleaned by pharmacy staff. Hot and cold running water, hand towels and hand soap were available. The pharmacy had air conditioning and the temperature in the dispensary felt comfortable during the inspection. Lighting was adequate for the services provided. There was a private soundproof consultation room which was signposted and being used throughout the inspection for vaccinations.

The consultation room was professional in appearance. It had direct access to the dispensary via a small doorway which allowed the vaccinator to store vaccines safely in the dispensary but still have easy access to them. There was a large waiting area available. Additional chairs had been purchased and could be put out if there was a busy vaccination session. The vaccinator had clinical wipes available and cleaned the consultation room at regular points throughout the day.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. People receive appropriate healthcare information and advice about their medicines when collecting their prescriptions or receiving a pharmacy service. But people supplied with compliance packs may not get all the information that they need about their medicines. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use.

Inspector's evidence

The pharmacy had step-free access from the pavement. The pharmacy team referred people to other local pharmacies if they required a home delivery service. They used local knowledge and the internet to support signposting. There was a large health information zone, with various health promotion leaflets and information in the shop. The doctor provided healthy living advice whilst he carried out the COVID and flu vaccinations. A monthly healthy living newsletter was available, and back-copies were retained so that they could be given to people who requested information about various medical conditions. The pharmacy team kept a large range of vitamins and supplements in stock and gave people information on simple diet changes, such as switching from fizzy drinks to water or sugar-free squash to improve their health. Pharmacy staff were observed speaking to people in different languages throughout the inspection. Staff could communicate with people in English, Punjabi, Hindi, and Urdu.

The COVID vaccination service was available at the pharmacy and people booked appointments for a vaccination on the NHS booking system. The doctor that delivered the service informed the NHS area team of his upcoming availability and the booking diary was updated. The pharmacy offered a walk-in service. When the vaccinations were removed from the fridge, they were marked with the time that they would need to be discarded if they had not been used. Vaccination records were made onto the NHS system and there was a computer in the consultation room so these records could be made in real time. The doctor could not immediately locate an anaphylaxis kit, so it was suggested that this was put in an easily accessible position in the consultation rooms so that it was available in the event of an emergency.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available, and the pharmacy had put a ‘pop up’ warning note onto the PMR of people prescribed valproate to remind the team to council them on the Pregnancy Prevention Programme each time.

Multi-compartment compliance packs were used to supply medicines for some people. Prescriptions were ordered in advance to allow for any missing items or changes to be queried with the surgery ahead of the intended date of supply. Each person had a record to show what medication they were taking and how it should be packed. Notes about prescription changes and queries were kept on the PMR. Descriptions of medicines included on packs were not always accurate and patient information

leaflets were not supplied. This meant that people may not have all the information that they require about their medicines. The SI occasionally carried out an informal suitability assessment when there was a request for a new compliance pack if he was unaware of the patient's history or reason for requesting the pack.

The pharmacy was date checked every three months and short-dated medicines were clearly marked with a sticker. Some out-of-date medication was found during the inspection. These medicines had stickers to indicate they were short dated, but they had expired since the date of the last date check (July 2023). Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licensed wholesalers. Drug recalls were received electronically and marked when they were actioned.

The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8° Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The team uses this equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available. Computer screens were not visible to members of the public as they were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.