General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Cohens Chemist, 109 - 111 High Street, BONNYRIGG, Midlothian, EH19 2ET

**Pharmacy reference:** 1091136

**Type of pharmacy:** Community

**Date of inspection:** 26/09/2019

## Pharmacy context

This is a busy community pharmacy in a health centre. The pharmacy dispenses NHS prescriptions and supplies medicines in multi-compartmental compliance packs. It also provides substance misuse services. And sells a small range of over-the-counter medicines.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## 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 members follow written processes for all services to ensure they are safe. They record mistakes to learn from them. And they make changes to avoid the same mistake happening again. The pharmacy uses feedback from people to make its services better. It keeps all the records that it needs to by law and keeps people's information safe. Team members help to protect vulnerable people.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for most activities and tasks. Team members did not follow all the details of the process for multi-compartmental compliance packs. For example, they were not using a progress log. And they did not label and endorse prescriptions before the clinical check. (They highlighted changes to the pharmacuist at the time of assembly.) Pharmacy team members had read SOPs and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs, an index page and a 'roles and responsibilities' SOP. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They could describe the different roles of e.g. pharmacy technicians, accuracy checking dispensers and colleagues not yet fully trained and competent to undertake some tasks. The pharmacy technicians had greater responsibilities with some high-risk activities such as managing 'specials' and auditing controlled drug (CD) running balances. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. Accuracy checking dispensers only carried out this task if a pharmacist had signed prescriptions indicating that a clinical check had been completed. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. But their use of this was inconsistent. Sometimes they recorded their own errors and sometimes the pharmacist or accuracy checker did it. They also recorded errors reaching patients to learn from them. They reviewed these and discussed them, but this was not documented and was not a regular structured process. The pharmacy team made changes to reduce the risk of the same mistake happening again. This included separating similar sounding or looking items e.g. cyclizine and colchicine. Team members described constantly reviewing and separating items as packaging frequently changed.

The pharmacy had a complaints procedure and welcomed feedback. Team members kept specific brands of medicines for some people. They kept these in separate drawers. And they recorded these preferences on patients' medication records.

The pharmacy had indemnity insurance expiring 31 August 2020. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient

medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed a SOP. They segregated confidential waste for secure destruction by the local NHS. People could see dispensing activities so team members described taking care to try and avoid people seeing medicines being selected for waiting prescriptions. They also described trying to take phone calls towards the back of dispensary to limit what people could overhear. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew that information on raising concerns locally was available on the internet. The pharmacists were PVG registered.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough trained or training team members to safely provide its services. Trainee team members have time set aside to complete their course work. Pharmacy team members make decisions and use their professional judgement to help people. They can make suggestions to improve services. And they discuss incidents to learn from them.

### Inspector's evidence

The pharmacy had the following staff: two full-time pharmacist managers, two full-time accuracy checking dispensers, three full -time pharmacy technicians, five full-time dispensers (one was also a supervisor), one full-time trainee medicines counter assistants, and 2 part-time delivery drivers. All dispensers had completed medicines counter training. Team members were able to manage the workload. But lack of space was observed to pose some challenges, such as difficulty finding enough space to work and sometimes not enough space to pass colleagues. The pharmacy used rotas to ensure all team members were involved in all activities. This ensured they maintained their skills in each area and did not get bored or complacent undertaking repetitive tasks.

The pharmacy provided protected time for all team members to read SOPs and other information. But it did not have structured or regular training or development in place. Team members undertaking accredited courses had protected time at work to complete course work. A recently qualified pharmacy technician described half-a-day per week, and support from colleagues. The new trainee medicines counter assistant had not yet started accredited training. She had received on-the-job coaching to enable her to take in prescriptions and follow the sale of medicines protocol. The pharmacists supervised the trainee team member. And she was aware of her limitations.

Team members asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. The pharmacists and pharmacy technicians attended local events as they were available. This included a forthcoming event on the NHS urgent supply service. They described being on track with all aspects of re-validation and were supporting each other. They were using an incident elsewhere as a peer review topic. And they were reflecting how they would deal with a similar situation in this pharmacy. The accuracy checking dispensers kept their portfolios up-to-date. A pharmacist reviewed and signed their records.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They had occasional ad-hoc meetings in small groups where they discussed a variety of topics e.g. managing the queue at the front counter and supporting colleagues to do this. Team members could make suggestions and raise concerns to the pharmacy managers or head office. They described examples of a team member suggesting a change to medicines' organisation in the dispensary. The team discussed this and then implemented it, using the expertise of team members involved in stock control. They gave appropriate responses to scenarios posed. The company had a whistleblowing policy that team members were aware of. The company set targets for dispensing volume. Team members described how they used this. They explained that good stock management resulted in medicine availability. This benefited people as they did not need to go to another pharmacy.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

### Inspector's evidence

These were small premises in two rooms within a large health centre. The dispensary was small for the volume of dispensing, with limited dispensing bench and limited storage. Team members were observed having difficulty finding space to work and move about the dispensary, particularly after the medicines' delivery arrived, taking up space until stock was put away. The pharmacy required a lot of space to store dispensed medicines. And dispensed medicines waiting to be checked took up a lot of dispensing space. The pharmacy did not have a retail area but had a small range of pharmacy medicines at the prescription reception counter. The pharmacy's main business was dispensing. It had a room that was used for the management of multi-compartmental compliance packs and provided staff facilities. The pharmacy used a room in the health centre for private consultations and supervision of methadone consumption. This room did not form part of the registered pharmacy premises, but the pharmacy manager explained that he would address this. The premises were clean, hygienic and well maintained. There were sinks in the dispensary and staff room. These had hot and cold running water, soap, and clean hand towels.

People could see activities being undertaken in the dispensary due to the open design. These included dispensing and stock management. The pharmacy had recently installed frosted glass above a front facing dispensing bench to provide some privacy. Temperature and lighting were comfortable.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

### Inspector's evidence

The pharmacy had good physical access with car parking, a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. Team members provided large print labels to people with impaired vision. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy had two dispensing processes, one for 'walk-in' prescriptions and one for collection service prescriptions. A pharmacist checked all 'walk-in' items on a bench behind the 'walk-in' dispensing bench and facing the front-shop. This meant he could see the medicines counter and how many people were waiting in the pharmacy. The second pharmacist clinically checked the collection service prescriptions and signed them. Then they were dispensed in an adjacent area in the dispensary, usually with one team member labelling and another assembling. An accuracy checking dispenser checked these. But if there were any changes or new items the team member labelling drew this to the pharmacist's attention. The pharmacist undertook another clinical check and often accuracy checked. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with two assembled at a time. Team members took weekly turns at this task to ensure there was always competent cover for absence. There was always one team member assigned to this task, with another as back-up to help with busy periods. One team member was permanently working in this room for a period for health and safety reasons. She was agreeable to this. The pharmacy worked a week ahead to give ample time to address queries. So, team members were usually assembling packs for supply the following week. Team members followed a robust and methodical process for ordering and managing prescriptions. The pharmacy usually received prescriptions a week before they assembled the packs. A pharmacist clinically checked and signed them. A team member checked them for accuracy on the day of assembly. This meant that occasionally, if there were changes or omissions, trays had to be left open until new prescriptions were received. Team members produced backing sheets and labels, checking for accuracy throughout. As with other dispensing, team members highlighted any changes or new items to the pharmacist. They dispensed and labelled items in original packs, which were checked by a pharmacist or accuracy checker. Team members then assembled two weeks' tablets into the compliance packs and stored the remaining medicines in the person's basket. A pharmacist or accuracy checker checked the completed trays. The pharmacy stored completed trays in coloured baskets by day in this room. Team members included start date and tablet descriptions on backing sheets. And start date and instalment numbers on the pack. They supplied patient information leaflets with the first pack

of each prescription. Team members were not following the detail of the company SOP for this process. The SOP required labelling before clinically checking.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and chlamydia treatment. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. The trainee medicines counter assistant referred all requests for eMAS or sale of pharmacy medicines, after gathering the relevant information.

The pharmacy worked in partnership with nurses in the building to deliver the smoking cessation service. A local pilot involved nurse counselling and pharmacy supply. There was adequate nurse resource to provide longer appointments. The pharmacist prescribed following the nurse suggestion (if in agreement) and completed the relevant paperwork. People were benefiting from this service.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It was not yet fully compliant with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after this equipment to ensure it works.

### Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.The pharmacy had a carbon monoxide monitor maintained by the health board which team members did not often use. Nurses delivered the local NHS smoking cessation service. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. And they kept clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and office inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

## 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. |