General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 392A Little Horton Lane, BRADFORD, West Yorkshire, BD5 0NX

Pharmacy reference: 1091907

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

The pharmacy is adjacent to a health centre in the suburbs of Bradford. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs), the NHS New Medicines Service (NMS) and seasonal flu vaccinations. Pharmacy team members supply medicines to people in multi-compartment compliance packs. And, they deliver medicines to people at home. The pharmacy provides a substance misuse 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 procedures to identify and manage risks to its services. And pharmacy team members generally follow the pharmacy’s written procedures to complete the required tasks. The pharmacy protects people’s confidential information. And it keeps the records it must by law. Pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. They record and discuss some mistakes that happen when dispensing. But they dont record much detail about why mistakes happen. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2018. And the next review was scheduled for 2020. Pharmacy team members had read and signed the SOPs since the last review. The pharmacy defined the roles of the pharmacy team members in the SOPs. Each procedure was colour coded. And each colour represented different levels of qualification. For example, the steps that the pharmacist was responsible for were highlighted with one colour. And the steps that could be done by a dispenser were highlighted in another colour. Roles were further defined in a role matrix kept at the front of the SOP file. The pharmacy had up-to-date, signed patient group direction (PGD) and SOP in place for the flu vaccination service. And, the pharmacist had completed training in September 2019. He had completed a risk assessment checklist before the service was started to confirm the necessary documents and equipment were in place.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. He did not record all near miss error that happened. In the sample of records available, five near miss errors had been recorded since July 2019. Pharmacy team members said they were told about their errors. And, they were asked to fix them and to be more careful next time. They did not discuss or record any details about why a mistake had happened. And, they explained they did not usually hear about mistakes that had been made by other team members. The pharmacist analysed the data collected about mistakes. The documented procedure for handling near miss errors asked the pharmacy to analyse data about near miss every month. The pharmacist said he was behind and did not analyse the data monthly. He showed an example of an analysis of near miss data from June 2019. He had completed the analysis in October 2019. He analysed the data for patterns of medicines involved and the types of error, such as wrong strength or wrong form. He did not analyse the causes of the mistakes. And, pharmacy team members said they were not usually told about the outcome of the analysis. Pharmacy team members gave some examples of separating look-alike and sound-alike (LASA) medicines on the pharmacy’s shelves after near miss errors, such as pravastatin and pantoprazole. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system that submitted a report to the superintendent pharmacist (SI). The sample of reports seen gave details of what had happened. They did not give much information about the causes of the errors. Pharmacy team members gave some examples of changes they had made in response to dispensing errors. One example was separating different strengths of lansoprazole capsules after someone was provided with the incorrect strength.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company’s complaints procedure. But the poster was obscured by retail stock and could not be seen clearly. The pharmacy collected feedback

from people by using questionnaires. And information from analysis of the last set of questionnaires was displayed in the retail area. One example of a change made was the removal of a merchandise stand in the retail area after people had complained about lack of space.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity approximately monthly. But, registers for methadone were not audited frequently. For example, pharmacy team members had last audited the register of sugared methadone in August 2019. The documented procedure instructed pharmacy team members to audit stock of methadone weekly. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And, it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records electronically. But, some of the examples seen did not accurately record the date on the prescriptions. They recorded emergency supplies of medicines electronically.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And, these were collected and returned to head office for secure destruction. Pharmacy team members had been trained to protect privacy and confidentiality. But there was no evidence of when they had last completed their training. Pharmacy team members were clear about how important it was to protect confidentiality. But they could not find a documented procedure covering the requirements of the General Data Protection Regulations (GDPR). And, there was no evidence that the pharmacy had been assessed for GDPR compliance.

Pharmacy team members were asked about their role in safeguarding people. A dispenser gave some clear examples of symptoms that would raise their concerns in both children and vulnerable adults. And, how they would refer their concerns to the pharmacist. The pharmacist explained how they would assess the concern. And would refer to local safeguarding contacts or head office for advice. The pharmacy had contact details available for the local safeguarding service. And, it had a procedure in place to explain what to do in the event of a concern. The pharmacist had completed training in relation to safeguarding in 2019. And the pharmacy technician had completed training in 2017. There was no training provided for other pharmacy team members. Pharmacy team members explained how they were provided with some information verbally by the pharmacist and pharmacy technician.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete ad-hoc training. And, they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, four dispensers and a delivery driver. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacists about current topics and completing occasional material sent by head office. Pharmacy team members received an appraisal every year with the pharmacist. They explained they discussed all areas of their work. And identified areas where they could improve. They set objectives to address any learning needs. A dispenser explained that one of her recent objectives was to be more effective at checking multi-compartment compliance packs returned to the pharmacy from the company's dispensing hub. She said her objective was to check the packs returned the day before they were due to be delivered. And, this helped to give more time to deal with any issues, errors or discrepancies before packs were due to be supplied to people.

A dispenser explained she would raise professional concerns with the supervisor, pharmacist or coordinator. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, prescriptions for multi-compartment compliance packs that were to be dispensed at the company's off-site hub were processed by one pharmacy team member. They had raised concerns about the volume of work and that they felt unable to complete the work in time. The team had discussed the issue. And, the process had been changed. Now, two pharmacy team members were responsible for processing the prescriptions. And, a dispenser explained this had helped to reduce their pressure and complete the work on time.

The pharmacy owners asked the team to achieve targets in various areas of the business. These included the number of medicines use review consultations completed, the number of flu vaccinations provided, and the volume of prescriptions dispensed. The pharmacist said he felt comfortable achieving the targets set. And, the area manager supported him to achieve the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. But the area for dispensing is small for the volume of work undertaken. So, the team members work effectively to make sure they provide services safely. The pharmacy has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. It had a small amount of bench space available for the volume of dispensing being carried out. But all areas of the pharmacy were tidy and well organised. And, the floors and passage ways were generally free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And, the pharmacy has systems in place to help provide its services safely and effectively. It generally stores, sources and manages its medicines safely. The pharmacy dispenses medicines into devices to help people remember to take them correctly. And pharmacy team members manage this service well. They take steps to identify people taking high-risk medicines. And, they provide these people with advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street. Pharmacy team members used written communication to help people with a hearing impairment. And, they could provide large print labels for people with visual impairment. Some pharmacy team members spoke other languages besides English that were spoken in the local community. These included Punjabi, Hindi, Urdu and Arabic. Pharmacy team members said they would also use Google translate to communicate with people who could not use any of these languages as a last resort. One example was occasionally people from Eastern Europe accessing the pharmacy.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was enrolled on a pregnancy prevention programme. The pharmacy had printed information material to give to people and to help them manage the risks.

The pharmacy sent prescriptions for people who received their medicines in multi-compartment compliance packs to the company's off-site dispensing hub for the packs to be prepared. Pharmacy team members ordered prescriptions on the patient's behalf. These prescriptions were received by the pharmacy electronically. Pharmacy team members reconciled the prescriptions against their order. They resolved any discrepancies. And, they entered the information to be used on the backing sheet of the pack on to the electronic system. The pharmacist then clinically screened the prescription. And checked the information entered by the dispenser was accurate. They confirmed when their checks were completed by adding their registration number to the system. Then, they submitted the information to the hub electronically. Packs were assembled at the hub. And, were returned to the pharmacy approximately five days later. When the packs were received, a pharmacy team member checked them against the prescriptions to make sure they were correct. And, the pharmacist carried out a final check, before packaging the packs ready for delivery. The packs had backing sheets attached, so people had written instructions of how to take the medicines. And, these included photographs and descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines every two months. They recorded any changes made to people's medication on their individual master record sheet. Sometimes the record did not include details of the prescriber initiating the change. This would help deal with future queries. The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if

someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet. And, people signed for CDs in a separate record book.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet tidy and well organised. And out of date and patient returned CDs segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had new scanners and software available. But they had not received any training. And, the pharmacy did not have procedures that incorporated the requirements of FMD in to the dispensing process. Pharmacy team members said they were waiting for further instructions from head office about the rollout and implementation of FMD requirements. They did not know when this would be. Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. But they didn't have a process to remove any medicines that expired before the next date check. They would only do this if someone noticed the sticker. After a search of shelves, the inspector did not find any out-of-date medicines. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. Pharmacy team members used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge, which was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment and they stored all items securely.

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.