General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, The Merritt Medical Centre, Merritt Gardens, CHESSINGTON, Surrey, KT9 2GY

Pharmacy reference: 1092719

Type of pharmacy: Community

Date of inspection: 23/03/2023

Pharmacy context

This is a community pharmacy. It is attached to a health centre in a residential area of Chessington. It provides a range of services including dispensing prescriptions. And it has a selection of over-the counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it offers a winter flu vaccination service and a blood pressure monitoring service. It also delivers medicines to people who have no other means of getting their medicines from the pharmacy.

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	1.4	Good practice	The pharmacy team is good at responding to people's feedback. And it takes timely action to ensure that people get their medicines when they need them.
2. Staff	Standards met	2.2	Good practice	The pharmacy develops and supports its team members well. And it gives its team members good support and feedback to help them carry out their tasks well.
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 suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy had a system for recording its mistakes. The regular responsible pharmacist (RP) was also the manager. And he worked at the pharmacy full time. The RP described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. He conducted a patient safety review each month and discussed his findings with the team. He then submitted those findings to head office. Each year the company gathered information from the results of all the reviews. They did this to monitor the types of mistakes that happened and to monitor improvement. After identifying a near miss the RP asked the relevant team member to look at what they had dispensed and find the mistake themselves. He found that by doing this, they were less likely to repeat them. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). It had placed a list of common LASAs on the wall to make the team aware of them. In response to a mistake between atorvastatin 10mg and amlodipine 10mg, team members now underlined the names of LASAs on prescriptions whenever they came across them. They did this to prompt additional checks during dispensing and checking. And this approach had successfully reduced the occurrence of LASA mistakes. But while it was clear that the team recorded and discussed its mistakes. And it took action in response to them, it did not fully record what had happened or what it had learned. The RP and inspector discussed this and agreed that by recording more detail of what had happened, team members could identify steps in their procedure which would prevent a repeat of similar mistakes in future. And this would help the RP to monitor improvement even more effectively.

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. It had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. The pharmacy had a set of up-to-date standard operating procedures (SOPs) to follow. SOPs were available electronically. And so, they and any updates to them could be accessed easily by the team. Staff understood their roles and responsibilities. The medicines counter assistant (MCA) was a longstanding member of the team. She consulted the pharmacist and her other colleagues when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. The RP had placed his RP notice on display where people could see it. The notice showed his name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback to head office. In the past people had fed back that they did

not like it when their medicines were not ready when they expected them to be. So, the team advised them to allow more time between ordering their prescriptions and collecting their medicines. They explained that this was because the pharmacy needed time to access their prescriptions. And to sort out any problems and dispense their medicines safely. The pharmacy also now sent a text message to people directly from its patient medication record (PMR) system to let them know when their medicines were ready. Other people had been concerned when the pharmacy did not have their medicines in stock. Or when there were manufacturers' shortages such as for hormone replacement therapy (HRT). Again, the team took time to explain the situation. But to prevent people from going without their medicines, as soon as the team received a prescription for an item it could not easily get, it contacted the surgery to suggest a suitable alternative. People had commented to the team that even if one of their medicines was delayed, they would prefer to know when the rest of their medicines were ready so that they could collect them. And so, team members now used the PMR system to let them know. The pharmacy had a complaints procedure in place. And team members could provide people with details of where they should register a complaint if they needed to. But the RP generally dealt with people's concerns at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record, its private prescription records. And records of its emergency supplies. It had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste containers as they worked. And they discarded the contents of the containers into confidential waste bags each day. All confidential waste was collected regularly for safe disposal by a licensed waste contractor. And the team kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not yet had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has an appropriate range of skills and experience to support its services. And it develops and supports its team members well. It manages its workload safely and effectively. And Its team members work effectively together. And they keep their knowledge up to date. Team members receive good support and feedback to help them carry out their tasks well.

Inspector's evidence

The company grouped its pharmacies into several regions. And this pharmacy had five other pharmacies in its region. Each region had a management support pharmacist. And a dedicate regional coordinator to assist with human resources, training and staff planning tasks. The RP attended weekly regional meetings. And through these meetings, he and his colleagues discussed issues affecting their pharmacies. And they helped each the find solutions such as by sharing staff. And they kept up to date with current concerns, business updates and priorities. The RP could make day-to-day professional decisions in the interest of patients. And he felt supported in his role by his team, his colleagues, and his line managers. The RP had certificates to show that he had completed appropriate training by a suitable training provider on several relevant topics such as sepsis, domestic abuse and antimicrobial stewardship.

On the day of the inspection the RP was on duty along with two accuracy checking dispensing assistants (ACD)s, a trainee dispensing assistant (DA) and the MCA. The team kept the daily workload of prescriptions in hand. And team members worked closely with one another. The dispensing team had three distinct workstations. And each one was for a separate set of tasks. Each day team members worked at a different station to the one they had worked on the day before. This allowed them to keep up to date with each set of tasks. And it provided an appropriate amount of variety in their day-to-day activities. Team members assisted each other when required. The team member working at the workstation closest to the counter was prioritised to help on the counter when needed. And when further help was needed, the one working at another workstation was prioritised as the second to go to help. The trainee DA sought the help of more skilled and experienced team members when she needed it. And she dealt with queries promptly.

The RP kept team members up to date by cascading information from regional meetings. And alongside regular team meetings, or ‘huddles’ he had regular one-to-ones with them. In one-to-ones he discussed any training and development needs. And staff could raise their concerns and provide feedback. Team members did not have formal reviews about their work performance. But they discussed issues as they worked. The RP held three-monthly training reviews for those in training. And ACDs were monitored regularly for checking accuracy by the RP. Team members also kept their knowledge up to date by reading medicines information and training material when they could. And they were encouraged to complete company training to develop their careers if they wanted to. One of the ACDs had recently attended a head office training course to become a supervisor.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they provide enough space for those services. They are tidy and organised. And they are sufficiently clean and secure.

Inspector's evidence

The pharmacy was in a self-contained area within the health centre. It had both an independent external door from a shared foyer. And an internal entrance which linked it with the health centre. It had a good-sized customer area. And a consultation room and a waiting area. And it had a long medicines counter with a spacious dispensary behind. The pharmacy stocked a core range of products for sale. The products related to health and personal care and were suitable for sale in a pharmacy. The pharmacy had a bright, modern appearance. And it was clean, tidy and well maintained. The team had a cleaning rota which involved a regular cleaning routine. And it cleaned the pharmacy's worksurfaces, floors and touch points regularly.

The medicines counter had a half-height backwall behind it for displaying over-the-counter medicines. And screens along the countertop helped to prevent the spread of infections. The pharmacy's consultation room was clean, tidy and organised. And as well as having an entrance from the shop floor, the consultation room also had an access door from the dispensary for the pharmacist. The dispensary had workbenches along three sides. And an island in the middle provided additional worksurface. All worksurfaces had storage areas above and below. The dispensary also had a run of pull-out drawers for storing medicines. Completed prescriptions ready for collection were stored in the dispensary on an area of shelving which was out of people's view. And in drawers behind the counter where they could not be seen. The dispensary was clean and tidy. And worksurfaces and floors were free of unnecessary clutter. The pharmacy also had a staff area and a stock room to the rear. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And it ensures that it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. In general, the pharmacy ensures that all its medicines are stored correctly.

Inspector's evidence

The pharmacy had step-free access. And its customer area was free of unnecessary obstacles. And it had a delivery service. The service was limited to people who had no other way of getting their medicines. The pharmacy could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. And it separated prescriptions into those with a small number of items from those with several items. So that it could process people's prescriptions more efficiently.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people could find the information they needed if they wanted to. The pharmacist gave people advice on a range of matters. And he would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP described how he would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the appropriate patient cards and information leaflets each time.

The pharmacy offered a hypertension case finding service. And the pharmacist used the pharmacy's patient medication record (PMR) system to identify people who might benefit from the service. These were often people on regular repeat prescriptions. The RP also referred people back to their GP where further medical intervention was required. The RP had referred several people to their GPs following a high blood pressure reading. And several of those had returned to the pharmacy with a prescription for blood pressure lowering tablets. The pharmacy also offered a new medicines service (NMS). Its patient medication record (PMR) system recognised when someone had been prescribed a new medicine. Team members identified this from the PMR. And they notified the pharmacist. The pharmacist then provided appropriate counselling and offered follow up appointments to answer any queries and offer advice. And to support the person to take their newly prescribed medicine. They did this after gaining the person's consent. And to show that the follow up appointments had been completed. The RP kept records to manage the process.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But the inspector found a brown dispensing bottle containing loose tablets which had been labelled with the name of the product, its strength and form and its expiry date. But the label did not contain any of the other manufacturer's information such as batch number or product licence number. And so, they could be missed if they were part of a medicines recall. The inspector discussed this with the RP. And they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing.

The pharmacist had risk assessed the delivery service. And he was in the process of assessing which people needed the service to continue. And those who could either come into the pharmacy themselves or find someone else to collect their medicines for them. The pharmacist talked to people before agreeing to deliver their medicines. He did this to ensure that it was safe to deliver to an agreed place if someone was not at home. The delivery driver kept records of all deliveries. And of medicines brought back to the pharmacy if they could not be delivered.

The pharmacy stored its medicines stock in a tidy and organised manner. It date-checked its stock regularly. And it kept records to show what had been checked and when. The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient’s agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had two computer terminals which it had placed at a workstation in the dispensary and in the consultation room. Computers were password protected. But team members used each other's smart cards from time to time. This meant that access to patient records were not accurately audited. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions out of people's 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.