

# Registered pharmacy inspection report

**Pharmacy Name:** Cohens Chemist, 256 Stockport Road, Cheadle Heath, STOCKPORT, Cheshire, SK3 0RG

**Pharmacy reference:** 1093324

**Type of pharmacy:** Community

**Date of inspection:** 27/08/2019

## Pharmacy context

This is a conventional community pharmacy situated on a busy main road in an urban residential area. It serves the local population and it mainly supplies NHS prescription medicines. It orders prescriptions on behalf of people and it prepares some of these medicines in weekly compliance packs to help make sure people take them safely. The pharmacy also offers home deliveries.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	2.1	Good practice	Staff do not feel pressurised when working and complete tasks properly and effectively in advance of deadlines. And the pharmacy reviews its staffing levels so that they remain appropriate.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Overall, the pharmacy manages its risks well. The pharmacy team follows written instructions to help make sure it provides safe services. The team reviews its mistakes which helps it to learn from them. Pharmacy team members receive training on protecting people's information, and they understand their role in protecting and supporting vulnerable people.

### Inspector's evidence

The pharmacy had written procedures that had been issued in July 2018 and were scheduled to be reviewed in July 2020. These covered safe dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CD). Records indicated that all the staff except a trainee dispenser had read and understood the procedures relevant to their role and responsibilities. The trainee was not present, but other staff suspected that they had read the procedures.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each prescription medication they supplied. And it assisted with investigating and managing mistakes. The pharmacy team discussed and recorded any mistakes it identified when dispensing medicines. It addressed each of these mistakes separately by, for example, adjusting where it stored similar sounding medicine names. However, staff usually did not record the reason why they thought they had made each mistake. And these records had not been reviewed for around twelve months whilst the manager, who was the resident pharmacist, had been absent. So, staff could miss additional opportunities to learn and mitigate risks in the dispensing process.

The pharmacy team received positive feedback across several key areas from people who used its services in its last satisfaction survey conducted between April 2017 and March 2018. The pharmacy had a complaint handling procedure which the staff had read. However, it did not publicly display any information about how to make a complaint.

The pharmacy had professional indemnity insurance for the services it provided. The RP displayed their RP notice, so the public could identify them. The pharmacy maintained its records required by law for the RP, CD and private prescription transactions. It also maintained its records for Medicines Use Reviews (MURs) and special medicines it had supplied to people. It kept the necessary records for the few emergency medication supply requests it received from people.

The pharmacy obtained people's written consent to provide the MUR, prescription ordering service and EPS. But it did not file the prescription ordering or EPS consent records in any order, which could make it difficult finding information in the event of a query. Staff had read the pharmacy's data protection and GDPR policies, and they used passwords and their own NHS security cards to access people's electronic data. They also securely stored and destroyed confidential material. The pharmacy had not completed a data protection audit and it did not display any information about its privacy notice, so people may not know how to find out about its policies on protecting their data.

The team formally assessed whether people needed their medicines in a compliance pack and made a corresponding record of this. It also informally assessed whether they needed their medication limited to seven day's supply, which could help them to avoid becoming confused, but it did not keep a corresponding record of this. The pharmacy also kept records of each compliance pack patient's care

arrangements, including their next of kin details, which helped towards easy access to this information if needed urgently. The team had reported safeguarding concerns to the GP when people exhibited signs of confusion. In some cases, it led to the pharmacy dispensing their medicines in compliance packs.

The resident pharmacist had level two safeguarding accreditation, and records indicated all the staff except for the trainee dispenser had read the pharmacy's written procedures on safeguarding. The pharmacy also had the local safeguarding board's procedures and contact details.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough staff to provide safe and effective services. Team members work well together and qualified staff have the skills necessary for their roles. But they don't complete any ongoing training, so their knowledge may not always be fully up to date. And the pharmacy sometimes delays new team member's training, which could mean they don't develop the skills needed to provide services as quickly as they could do.

### Inspector's evidence

The staff present included the RP who was a locum pharmacist providing temporary cover, two experienced dispensers, a pre-registration pharmacist who recently started, and a new member of the pharmacy team who had started a week ago. They were due to start training to be a medicines counter assistant (MCA) and dispenser following a successful three-month trial period. The pharmacy's other staff included the resident pharmacist, two dispensers, and a trainee dispenser.

The pharmacy had enough staff to comfortably manage its workload. The team said that they usually had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via the prescription ordering and electronic prescription services and the pharmacy owner's hub pharmacy dispensed most of the compliance packs, which helped to maintain service efficiency. The pharmacy had a steady footfall, so the team avoided sustained periods of increased workload pressure and it could promptly serve people.

Demand for the pharmacy's prescription services was steadily rising, which had led to increasing the team's working hours. Only one team member could take planned leave at any time and staff increased their working hours to cover if one of the full-time dispensers were on leave. The pharmacy had two pharmacists who provided stable cover for nine out of the last twelve months while the resident pharmacist had been on long-term leave. And other regular pharmacists provided shorter periods of cover for the preceding three months.

Staff worked well both independently and collectively. They used their initiative to get on with their assigned roles and did not need constant management or supervision. This was reflected in the two experienced dispensers who efficiently covered the compliance pack service.

The trainee dispenser, who started six months ago, had only recently started their training course because they were waiting for the resident pharmacist to return to work so they could provide guidance and support. Staff not had an appraisal for more than a year. And they did not have access to any ongoing training programme that helped to keep their skills and knowledge up to date.

The pharmacy had targets for the number of MURs it completed, which staff said did not significantly affect their ability to manage the dispensing workload.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises are clean, secure and spacious enough for the pharmacy's services. It has a private consultation room, so members of the public can have confidential conversations and maintain their privacy.

### Inspector's evidence

The level of cleanliness was appropriate for the services provided. The premises had the space that the staff needed to dispense medicines safely. And they could secure it to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's working practices are suitably effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy was open from 8.30am to 6pm Monday to Friday. It had step-free access and the team could see and assist people who needed help entering the premises.

The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including insulin, anti-coagulants, methotrexate and lithium. One of the dispensers had completed valproate training, but the other team members had not, and they did not know about the risks associated with dispensing valproate. Staff had completed a brief check of valproate patients, which did not identify anyone in the at-risk group. The pharmacy had not completed a formal audit of its valproate patients, but the resident pharmacist said they reviewed people on valproate when they presented their prescription for the first time. They would counsel and issue the MHRA approved guidance to anyone that was in the at-risk group.

The pharmacy regularly checked that patients on higher-risk medicines had a recent blood test. It also checked if they were experiencing any side effects or interactions when it dispensed each prescription, and at the time of MURs, so that they got the information they needed.

The team prompted people to confirm the repeat medications they required. This helped it limit medication wastage and people received their medication on time. And the team made records of these requests, but it did not include the medications requested, so could find it difficult to effectively resolve queries if needed.

The team scheduled when to order prescriptions for people who used compliance packs, so that it could supply their medication in good time. The team kept a record of these people's current medication that also stated the time of day they were to take them. This helped it effectively query differences between the record and prescriptions with the GP surgery, and reduced the risk of it overlooking medication changes. The pharmacy also kept detailed communications about medication queries or changes for people using compliance packs. The team labelled compliance packs that it prepared with a description of each medicine inside them, which helped people to identify them. The pharmacy owner's hub pharmacy also prepared some of the pharmacy's compliance packs with printed images of each medication. However, some images did not clearly show each medication's markings, so it could be more difficult for people to identify some of their medicines.

The team used baskets during the dispensing process to separate people's medicines and organise its workload. It marked part-used medication stock cartons, which helped make sure it gave people the right amount of medication.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. It did not have a system required to follow the Falsified Medicines Directive (FMD), as required by law, and staff did not know when it would be installed.

The pharmacy suitably secured its CDs and properly segregated date-expired and patient-returned CDs. And it had destruction kits for destroying CDs. The team suitably monitored the medication refrigerator storage temperatures, and records indicated that the pharmacy monitored medicine stock expiry dates over the long-term. The team took appropriate action when it received alerts for medicines suspected of not being fit for purpose and kept corresponding records. It disposed of obsolete medicines in waste bins kept away from its medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable.

The team used an alpha-numeric system to store patient's bags of dispensed medication, which meant it could efficiently retrieve people's medicines when needed.

The staff labelled dispensed CDs with a reminder for the pharmacist to check the prescription issue date when they supplied them, which helped to make sure they only supplied CDs against a valid prescription.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. It properly maintains its equipment and it has the facilities to secure people's information.

### Inspector's evidence

The team kept the dispensary sink clean; it had hot and cold running water and an antibacterial hand-sanitiser. The team had a range of clean measures. So, it had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. Staff used the latest versions of the BNF and cBNF to check pharmaceutical information if needed.

The team had facilities that protected peoples' confidentiality. It viewed people's electronic information on screens not visible from public areas and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public 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.