General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 8 Eastland Road, Thornbury, BRISTOL, Avon, BS35 1DS

Pharmacy reference: 1095141

Type of pharmacy: Community

Date of inspection: 04/11/2019

Pharmacy context

This is a community pharmacy in a residential area on the outskirts of the town of Thornbury. Most people using the pharmacy are elderly. The pharmacy dispenses NHS and private prescriptions and sells over-the counter medicines. It also supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy team does not identify and manage risks. And, the working areas are untidy and disorganised and this increases the risk of mistakes.
		1.2	Standard not met	There is insufficient recording, reflection and learning from mistakes to prevent them from happening again.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough staff to manage its workload safely.
		2.2	Standard not met	Team members in training do not receive dedicated learning time. And, so are inadequately supported.
3. Premises	Standards not all met	3.1	Standard not met	Not all parts of the pharmacy look professional. Areas are untidy which increase the likelihood of errors. And, the pharmacy is doing some activities for which they have inadequate space.
		3.2	Standard not met	Clear glass panels in the consultation room door mean that people's confidentiality cannot be maintained.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The services are not all effectively managed to make sure that they are delivered safely. The lack of training of some team members means that sometimes the pharmacist is not aware of issues that may need her intervention.
		4.3	Standard not met	Medicines are not always stored or disposed of safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team do not identify and manage risks. The pharmacy has written procedures but the appropriate sections are not all signed by the team members to show that they have read and understood them. There is insufficient recording, reflection and learning from mistakes to prevent them from happening again. The working areas are untidy and disorganised and this increases the risk of mistakes. The team members ask customers for their views but they do not act on the feedback to improve services. They generally keep people's private information safe but they are not sure about the company procedures for this. And, the team members have not completed any training on the new data protection regulations. Not all the team members know how to protect vulnerable people. The local telephone numbers to escalate any concerns are not available. The pharmacy generally keeps the up-to-date records that it must by law and it is appropriately insured to protect people if things go wrong.

Inspector's evidence

The pharmacy team did not identify and manage all risks. There had been a dispensing error on 16 October 2019 where isosorbide dinitrate 10mg had been given against a prescription calling for 20mg. Two pharmacists had been responsible for the error. The trainee dispenser seen said that she was not aware of the error and that it had not been thoroughly discussed. An incident report had been completed but it did not include any learning points or actions taken to reduce a similar recurrence. Near misses had not been recorded for several months. The pharmacy manager said that she had insufficient time to do this.

The dispensing areas were limited in size and at the time of the inspection, disorganised. A front area, at right angles to the medicine counter, was cluttered. Baskets were stored on top of one another which increased the risk of errors. Several prescriptions and repeat prescription slips were on the bench in no particular order. The back dispensing area was also cluttered. There was no clear dedicated checking area. Baskets, waiting to be checked, were stored on top of one another. In addition, the name and address labels were placed on the rim. This increased the likelihood of transference to the wrong basket and hence a potential error. Baskets of medicines waiting to be checked were stored on the floor including one multi-compartment compliance aid which had a note attached, 'urgent'. No one seen knew anything about this.

Several boxes of stock were also stored on the floor which further reduced the already limited space. In addition, the pharmacy had wholesaler dealer authorisation (WDA) from the Medicines and Healthcare products Regulatory Agency (MHRA). A very small area in a small stock room was used for this. This area was untidy. Moreover, having to comply with the company's requirement for this, impacted greatly on staff time.

Only two people were working in the pharmacy on the day of the inspection, the pharmacist and a NVQ2 trainee dispenser (see further under principle 2). They said that they were three days behind with their work schedule.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those for collection and those for delivery. There was a clear audit trail of the dispensing process and all the

‘dispensed by and checked by’ boxes on the labels examined had been initialled.

Up-to-date and relevant standard operating procedures (SOPs) were in place. The trainee dispenser said that she had read the SOPs but that she was not sure which ones she should sign. The pharmacist had not signed all the SOPs. The SOPs were reviewed every two years by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs. But, there was no displayed sales protocol or questions to be asked of customers requesting to buy medicines. As mentioned above, the only other person working with the pharmacist on the day of the visit was a newly appointed trainee dispenser. She was not aware of ‘prescription only medicine’ (POM) to ‘pharmacy only medicine’ (P) switches, such as chloramphenicol eye drops and did no know that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush. She did however say that she would refer anything that she was not sure of to the pharmacist and she was seen to do this with a person complaining of a sore throat.

The pharmacy did an annual customer satisfaction survey. In the 2018 survey, 90% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. But, there had been some feedback about providing healthy living advice. Currently, only the pharmacist was qualified to do this.

Public liability and indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 August 2020 was in place. The responsible pharmacist log, controlled drug (CD) records, specials records, fridge temperature records and date checking records were in order. But, the records for patient-returned CDs had several entries that had not been signed as witnessed as being destroyed. Private prescription records were kept electronically. Many of these did not include the prescriber details. And, the private prescriptions were haphazardly stored.

The staff seen were not sure if there was a dedicated information governance procedure. They had not done any training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. But, an NHS smart card belonging to someone not working on the day of the visit, was seen to being used. The consultation room had two glass panels which meant that patient confidentiality cannot be maintained in here. Confidential information was stored in the consultation room but there was Digi-pad access to this room. Confidential waste paper information was collected for appropriate disposal, but a large bag of this was occupying valuable space in the dispensary.

The trainee dispenser was not sure about the pharmacy’s safeguarding procedures. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. But, there were no local telephone numbers to escalate any concerns relating to both children and adults.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always have enough staff to manage its workload safely. There is evidence that the pharmacy team is not appropriately supported from higher management. Team members in training do not receive dedicated learning time. And, so are also inadequately supported. The trained team members do not do regular on-going learning and so their skills may not be up to date.

Inspector's evidence

The pharmacy was in a residential area on the outskirts of the town of Thornbury. They mainly dispensed NHS prescriptions with the majority of these being repeats. Several domiciliary patients received their medicines in multi-compartment compliance aids. Most of these were assembled off-site at Bolton. Those that were assembled weekly or those containing CDs and odd dosages were assembled at the branch. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist (who returned from maternity leave in May 2019), one part-time NVQ2 qualified dispenser (not seen) and one full-time NVQ2 trainee. They were currently advertising for a part-time medicine counter assistant. On the day of the visit, a Monday, there was just the pharmacist and the newly appointed, May 2019, trainee dispenser working. The pharmacy was at least 3 days behind with their workload. As mentioned under principle 1, all the dispensing areas were disorganised and cluttered. The pharmacist said that a qualified dispenser, working 32 hours each week had left on 3 October 2019. She had asked for extra help but this had only been provided in the last two weeks. The extra help provided was an additional pharmacist and dispenser on Tuesdays and an additional dispenser on Wednesdays and Thursdays. The pharmacy received no extra help on Mondays or Fridays. The visit took place on a Monday. It was seen during the visit that the pharmacist and trainee dispenser had difficulty in serving customers and dealing with prescriptions. The phone was consistently not answered. The trainee dispenser said that she found the situation stressful. And, she had received insufficient training on several topics, such as information governance and safeguarding (see further in principle 1 and 4). The part-time qualified dispenser did the best she could to cover any planned or unplanned absences. Help was given from other branches to cover planned holidays. The recruitment of a further staff member should somewhat ease the staffing situation.

The newly appointed trainee dispenser had no allocated learning time towards her course. The pharmacist said that the trained dispenser had no time to do any learning. None of the staff knew anything about the Falsified Medicines Directive (FMD). The pharmacist said that all learning was documented on her continuing professional development (CPD) records.

The staff did have meetings, usually in the lunch break when the pharmacy was closed. The pharmacist said that she was not unduly pressured to do the advanced NHS services. She said that she only did clinically appropriate reviews.

Principle 3 - Premises **Standards not all met**

Summary findings

Not all parts of the pharmacy look professional. Areas are untidy which increase the likelihood of errors. The pharmacy is doing some activities for which they have inadequate space. The consultation room is signposted so it is clear to people that there is somewhere private for them to talk. But, this room is not heated and so it may be uncomfortable during the winter months. And, clear glass panels mean that people's confidentiality in here cannot be maintained.

Inspector's evidence

Not all parts of the pharmacy presented a professional image. At the time of the inspection, the dispensing benches were cluttered which increased the risks of errors. The dispensing areas were small and several boxes and a large bag of confidential waste were seen to be stored on the floor. This further impacted on the already small space. In addition, the pharmacy had WDA from the MHRA (see under principle 1). There was inadequate space to deal with this extra stock. And, the store room used for this, was untidy. The mugs used on the Friday before the visit had not been washed up and the measuring cylinders needed cleaning.

The consultation room was signposted. But it was small. The door opened outwards which increased the available space and the pharmacy was not currently offering flu vaccinations. Two chairs in the consultation room were covered with fabric which may make them difficult to clean. There was a small sink but no heating and the room felt cold on the day of the inspection. Clear glass panels in the door meant that patient confidentiality could not be maintained. The room could also be tidier. In addition, some patient-sensitive information was stored in the consultation room. There was however Digi-pad access to the room and the pharmacist said that people were not left on their own. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

Most people can access the services the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The services are not all effectively managed to make sure that they are delivered safely. The lack of training of some team members means that sometimes the pharmacist is not aware of issues that may need her intervention. The pharmacy gets its medicines from appropriate sources. But, these are not always stored safely which may increase the risk of mistakes. And, they are not always disposed of safely. There could also be a better audit trail to show that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the front door to alert staff to anyone who may need assistance entering the pharmacy. There was no access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs) and the New Medicine Service (NMS). No enhanced services were currently offered.

Several domiciliary patients received their medicines in compliance aids (blister packs) but most of these were assembled off-site in Bolton. Those that were assembled weekly or those containing CDs and odd dosages were assembled at the branch. An area at the back of the pharmacy was used for the storage of the assembled blister packs. The domiciliary packs that were sent for off-site dispensing were all clinically checked by the pharmacist prior to this. There were folders for all the patients but not all of them had a completed backing sheet of the current medicines prescribed. This was being implemented. The pharmacist said that all changes or other issues were recorded on the patient's electronic prescription medication record. This was seen to have been done for one patient. Any discharge letters were printed off from PharmOutcomes and faxed to the appropriate surgery. The staff said that they had a good relationship with the local surgery.

There was a good audit trail for all items dispensed by the pharmacy. The pharmacist said that she routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. She also said that she counselled patients prescribed new drugs or any changes in dose. But, these were not routinely highlighted to her. And potential drug interactions were not printed off for her reference. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. Not all the staff were aware of the new sodium valproate guidance.

Suitable patients were encouraged to use the company's managed repeat prescription service to reduce wastage, to optimise the use of medicines and to identify any non-adherence concerns. But, whilst patients were asked to check that they still needed everything that they had ordered the previous month when they came to collect their medicines, they were not referred to the pharmacist if they said that they did not want a particular item. Potential non-adherence concerns were therefore not always identified.

The pharmacist reported that she sometimes identified during MURs that patients did not know what they were taking their medicines for and did not know that levothyroxine should be taken first thing in

the morning, before food and with water, not with tea containing milk.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, Phoenix and Cohens Head Office. Specials were obtained from AAH Specials. Invoices for all these suppliers were available. There was no scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD) and the staff had received no training on this. The CD cabinets were untidy which increased the likelihood of errors. And, money was stored in one cabinet which occupied valuable space and also potentially increased the people who accessed the cabinet in order to get change. There were no patient-returned or out-of-date CDs. But, as mentioned under principle 1, the records for several patient-returned items had not been signed as being witnessed as destroyed. The fridge was over-stocked and untidy. This too increased the likelihood of errors. The pharmacist said that she had asked the company for an additional fridge so that she could separate assembled medicines from stock medicines but that this had been denied. Other stock was also not tidily stored on the dispensary shelves. Several split boxes were stored under full boxes showing potential inadequate rotation of stock. And many boxes were not forward facing. Date checking procedures were behind schedule. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances. But, there was no list of these substances which should be treated as hazardous for waste purposes. The trainee dispenser had received no training on this and did not know that all preparations containing the sex hormones were treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. But, they were not signed or dated by the person checking the alert. Any required actions were not recorded and the alerts were not stored tidily. The pharmacy had received an alert on 25 October 2019. The pharmacist said that they had none of the affected batches but this was not recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 500ml). Several of these needed cleaning as did the sink. This was done during the visit. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were said to be cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2017/2018 Children's BNF. There was access to the internet.

The fridge was in good working order but overstocked and untidy. Maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.