General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, St Annes Primary Care Centre, Durham Avenue, LYTHAM ST. ANNES, Lancashire, FY8 2EP

Pharmacy reference: 1099894

Type of pharmacy: Community

Date of inspection: 06/08/2019

Pharmacy context

This is a community pharmacy inside a medical centre containing a number of GP practices. It is situated in the residential area of St Annes, on the Fylde coast. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services such as seasonal flu vaccinations. A number of people receive their medicines in multi-compartment compliance aids. An additional GP practice moved into the medical centre earlier this year which has resulted in the pharmacy dispensing a higher volume of prescriptions recently.

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	1.2	Good practice	Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.
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 follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. The pharmacy keeps most of the records it needs to by law. People who work in the pharmacy receive training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were issued in July 2018 and their stated date of review was July 2020. The pharmacy team had signed to say they had read and accepted the SOPs. They had also completed an assessment in June 2019 to check their understanding of the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved supplying the incorrect quantity of tablets. The pharmacist investigated the error and action was taken to help reduce the risk of further errors. For example, retraining staff to clearly mark any boxes which had been opened. Near miss errors were recorded on a paper log and the records were reviewed monthly by the pharmacist. The pharmacy team said the pharmacist would discuss the review with them each month. The pharmacist would also highlight mistakes to staff at the point of accuracy check and asked them to rectify their own errors. The reviews included clear examples of actions taken to help prevent similar mistakes. For example, asking staff to help locum pharmacists to dispense CD medicines to decrease the number of medicines which are self-checked. The company shared learning between pharmacies by intranet. Amongst other topics they covered common errors. The pharmacy team would discuss the information when it was received. A recent message involved making the pharmacy team aware about 'look alike, sound alike' medicines.

Roles and responsibilities of the pharmacy team were documented on a matrix. The dispenser was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. This was on display in the retail area and it advised people they could give feedback to members of the pharmacy team. Complaints were recorded to be followed up by the branch manager or the head office.

A current certificate of professional indemnity insurance was on display in the pharmacy. Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly. The balance of two random CDs checked and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, private prescriptions, and emergency supplies appeared to be in order. Records of unlicensed specials did not always contain the required information about who the supply was made to and when. This information is necessary to provide an audit trail in the event of a concern about the medicine.

An information governance (IG) policy was available. The pharmacy team had read the policy and

signed a confidentiality agreement. When questioned, the dispenser was able to describe what information was considered confidential and how it was segregated to be destroyed by the head office. Details about where to find the company's privacy notice was on display in the retail area.

Safeguarding procedures were included in the SOPs, which had been read by the pharmacy team. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were available in the consultation room. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. The pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, an accuracy checking technician (ACT), four dispensing assistants – two of whom were trained to accuracy check, four medicine counter assistants (MCA) – one of whom had recently commenced their role, and a driver. The pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist, an ACT, four dispensers and a counter assistant. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

The company provided the pharmacy team with some additional training. For example, learning topics such as dementia friends and healthy living pharmacy training packs. But further training was not provided in a structured or consistent manner, and records were not always kept. So learning needs may not always be fully addressed.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The locum pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team. The dispenser said she received a good level of support from the pharmacy team and felt able to ask for further help if needed.

Appraisals were conducted by the pharmacy manager. A dispenser said she felt that the appraisal process was a good chance to receive feedback on her performance and she felt able to speak about any of her own concerns. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. Targets were set for services for MURs and NMS. But the pharmacist said he did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. The temperature was controlled by the use of air conditioning. Lighting was sufficient. The staff had access to a kitchenette area and WC facilities.

A consultation room was available with access restricted by use of a lock. There was a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted. But it was cluttered with boxes and retail stock which detracted from the professional appearance expected of a consultation area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy team does not always identify people who receive higher risk medicines. So it might not always check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a medical centre and was suitable for wheelchair users. There was wheelchair access to the consultation room. Service panels and pharmacy practice leaflets gave information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder. The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded in a separate book for individual patients and a separate signature was obtained to confirm receipt.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. This would allow an accuracy checker to perform the final accuracy check. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is suitable for the patient. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Compliance aids were dispensed off-site at the

company's hub. Consent was not obtained from the patient for medicines to be dispensed off-site. So people may not be aware that their information is being shared in this way. The prescription was labelled electronically by a member of the pharmacy team. This was then checked by the pharmacist to confirm it was clinically appropriate and labelled accurately – which was auditable to indicate when this was completed and by whom. The medicines were dispensed into disposable equipment, with their location of dispensing, medication description and a dispensing check audit trail. Patient information leaflets (PILs) were not routinely supplied. So people may not have all of the information they need to take the medicines safely.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the Falsified Medicines Directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines.

Stock was date checked on a 12 week rotating cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short-dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There was a clean medicines fridge with a minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last three months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received electronically by email. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. There were no stickers attached to indicate they had been PAT tested.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for CDs. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide privacy.

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.