General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 11 Manchester Road, Haslingden, ROSSENDALE, Lancashire, BB4 5SL

Pharmacy reference: 1103523

Type of pharmacy: Community

Date of inspection: 09/06/2022

Pharmacy context

This is a community pharmacy in the village of Haslingden, Lancashire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. And it delivers medicines for some people to their homes. The pharmacy supplies some people living in their own homes with medicines in multi-compartment compliance packs. This helps them correctly take their medicines. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards 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 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 generally identifies and manages most of the risks associated with its services. The pharmacy team members mostly follow the pharmacy's written procedures to help them safely carry out tasks. They keep the records they need to by law, and they safely keep people's private information. The team is well equipped to manage any safeguarding concerns. But the team doesn't record or analyse all of the mistakes team members make while dispensing. And so, the team may miss out on the opportunity to improve patient safety.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. It had some procedures in place to help manage the risks and to help prevent the spread of coronavirus. These included notices reminding people visiting the pharmacy to wear a face covering. There was a plastic screen at the pharmacy counter to act as a protective barrier between team members and people visiting the pharmacy. The pharmacy's team members socially distanced from each other when they could. And the pharmacy had affixed arrows to the floor of the retail area to help people follow a one-way system. It had hand sanitiser placed in areas around the retail area and the dispensary to promote good hand hygiene.

The pharmacy had a set of written standard operating procedures (SOPs). The SOPs covered tasks such as dispensing and controlled drug (CD) management. They had last been reviewed in August 2020 and were due to be reviewed again in July 2022. Team members had been issued certificates to confirm they completed the task of reading and understanding the SOPs that were relevant to their role. A pharmacist signed record sheets to confirm team members understanding of the SOPs.

The pharmacy had a process in place for team members to record and report mistakes spotted by the responsible pharmacist (RP) during the dispensing process. These mistakes were known as near miss errors. When a team member spotted a near miss error, the RP informed the dispenser of the error and asked them to rectify the mistake. The pharmacy had a paper-form near miss log into which team members could record details of any near miss errors made. But team members had not used the log for several months and were unable to find it during the inspection. And so, they may have missed out on the opportunity to identify any trends or patterns to help them improve patient safety. The pharmacy kept records of any dispensing errors that had reached people. Any such incidents were immediately brought to the attention of the RP and steps were taken to rectify them. The team also contacted the pharmacy's superintendent pharmacist's (SI) office to inform them when a dispensing incident had happened. The SI office helped advise the team on what steps it could take to prevent a similar error happening again. The team held a meeting to discuss such incidents. And they talked about why the error might have happened and what they could do to improve patient safety. A team member, usually the RP, completed an incident report form. The form was stored in a file for future reference. Recently, the pharmacy had supplied a person with fluoxetine instead of flucloxacillin. The team felt the similarity in the names and location on the shelves contributed to the error. And it separated the two medicines on the dispensary shelves to reduce the risk of the incorrect medicines being selected in the future. The pharmacy had a formal concerns and complaints procedure. Any complaints or concerns were raised with a team member. If the team member could not resolve the complaint, it was escalated to the SI office.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice displayed the name and registration number of the RP on duty. The pharmacy correctly completed the RP register and kept it up to date. It kept complete and up-to-date registers of CDs. It completed regular balance checks. The inspector checked the balance of two CDs. Both were correct. The pharmacy occasionally dispensed private prescriptions and it kept records of supplies.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. It separated confidential waste to avoid a mix up with general waste. A third-party contractor periodically destroyed confidential waste. The team members understood the importance of ensuring they didn't discuss people's private information in areas of the pharmacy where they could be overheard by others. All team members had completed training on information governance and General Data Protection Regulation (GDPR). Team members had completed some basic internal training on safeguarding vulnerable adults and children. The RP had completed training through the Centre for Pharmacy Postgraduate Education up to level two. The team gave examples of symptoms that would raise their concerns and they knew how to appropriately report them. The pharmacy displayed a notice with a QR code in the retail area to help people access NHS East Lancs and Cumbria mental health support services.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the skills they need and they support each other as they work. This helps them to adequately provide the pharmacy's services. The team members have procedures in place to help them raise concerns, give feedback and suggest improvements to provide a more effective service. They are under some pressure to complete the workload in a timely manner. And the pharmacy doesn't always have the capacity to fully support team members in training roles to complete their training courses.

Inspector's evidence

At the time of the inspection the RP was a company employed relief pharmacist who worked across several of the company's pharmacies in the area. Two full-time trainee pharmacy assistants, a part-time counter assistant and two locum pharmacy dispensers supported the RP. The pharmacy also employed another part-time counter assistant and a part-time delivery driver. The pharmacy had not had a regular pharmacist for several months and had been using locum pharmacists to cover the opening hours. Team members explained they had found working without a regular pharmacist challenging and were looking forward to the pharmacy filling the vacant position over the next few months. Team members supported each other during the inspection. However, the team was behind with its dispensing workload, and they were observed working under some time pressures. On several occasions during the inspection, team members were unable to find people's dispensed prescriptions and were also unable to answer some phone calls. The pharmacy had used locum dispensers regularly over the previous few months. A pharmacy supervisor had recently been appointed and was due to start work in next few days. The supervisor was also a qualified dispenser and would help complete various administrative tasks. Team members explained they were pleased with the appointment and were looking forward to working with some increased direction and leadership.

The pharmacy had enrolled the two trainee dispensers onto approved courses. It provided protected study time to the trainees during their working hours to help them complete their course. But due to workload pressures they were unable to regularly take the time. They trained by learning while they worked but as the pharmacy didn't have a regular pharmacist or a manager, they were not given any mentorship. They had recently had a progress review but were unable to implement many of the ideas they had discussed to help them efficiently complete their courses. Team members explained the newly appointed supervisor would be monitoring their progress once they started working at the pharmacy.

The team held meetings on an ad-hoc basis. The pharmacy head office set some of the agenda points to be discussed and team members added additional points which were relevant to the pharmacy. Due to the recent workload pressures, the team had not been able to hold a formal meeting for several weeks. But team members discussed topics such as upcoming work streams and staff rotas while they worked. The pharmacy head office employed a pharmacy co-ordinator who occasionally visited the pharmacy. Team members were able to raise concerns and give feedback to the co-ordinator. For example, the team had recently asked for additional locum dispenser support to help them complete the dispensing workload in the run up to bank holiday weekends. The pharmacy had a whistleblowing policy in place to help team members to anonymously raise concerns. The pharmacy had set the team some targets for services although there was no pressure for it to meet them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure, and well maintained. It has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, well maintained, and mostly professional in appearance. Benches were cluttered with baskets containing prescriptions waiting to be dispensed. But this improved as the inspection progressed. The pharmacy’s floor space was mostly clear from obstruction. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process. The pharmacy had plenty of space to store its medicines. There was a private, sound-proofed consultation room available for people to have private conversations with team members. The room was tidy and well organised. It contained two seats and was large enough for two people to appropriately socially distance from each other when in use.

There was a first floor which contained a staff area and a room for storing miscellaneous items. The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it adequately manages the delivery of these services. The pharmacy correctly sources its medicines. But the team doesn't always follow its processes to check the medicines are in-date and fit for purpose.

Inspector's evidence

People had access into the pharmacy through the main entrance door. The pharmacy advertised some of its services and its opening hours in the main window. The pharmacy provided large print labels to people with a visual impairment. Team members had access to the internet which they used to signpost people requiring services that the pharmacy didn't offer. There were seats available in the retail area for people to use while they waited for their prescriptions to be dispensed. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They demonstrated the advice they would give in a hypothetical situation. And they demonstrated how they would attach warning stickers if they dispensed valproate in plain, white, medicine boxes. This was so people didn't miss out on important information about the risks of taking valproate in pregnancy.

Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. But when these situations occurred the team didn't always provide people with an owing slip. And so, people may not have had a record of what medicines they were outstanding. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy supplied medicines in multi-compartment compliance packs to around 200 people. Until recently, the packs were dispensed at a dispensing hub. This was to reduce the workload pressures on the team. In recent weeks, the hub was experiencing its own workload pressures. And so, packs that contained less than five medicines were dispensed by the pharmacy team. The team dispensed them on a designated bench in the dispensary. The bench was close to the pharmacy counter. Team members explained they need to occasionally stop the dispensing process to serve people in the retail area. This increased the risk of mistakes being made. Team members used master sheets which contained a list of the person's current medication and dose times. They checked prescriptions against the master sheets before the dispensing process started to make sure they were accurate. Team members discussed any queries with the relevant prescriber. They recorded details of any changes such as dosage increases or decreases on the person's master sheet and their electronic record. The pharmacy supplied the packs with patient information leaflets and with descriptions of the medicines to help people identify them. For example, 'orange, round, tablet'.

The pharmacy stored pharmacy (P) medicines behind the pharmacy counter. It stored other medicines in their original packaging on shelves. The pharmacy had medical waste bins, sharps bins and CD

denaturing kits available to support the team in managing pharmaceutical waste. There was a process for the team to follow to check the expiry dates of its medicinal stock. But the team had not completed the process for several months. Four out-of-date medicines were found after a check of around 20 randomly selected medicines. Two of these medicines had 'short-dated' alert stickers attached to them. Team members were not seen checking expiry dates as they dispensed medicines. The team gave the inspector assurances that completing the date checking process would be prioritised following the inspection. The pharmacy used one medical grade fridge to store medicines that needed cold storage. The team kept daily records of the fridge temperature ranges. And a sample of the record indicated the fridge was operating within the correct range. However, during the inspection the inspector checked the temperature ranges. The maximum temperature was higher than the accepted range and this had not been accounted for. The RP gave assurances the fridge would be closely monitored to ensure it was correctly operating.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. It stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn’t see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. Team members had access to personal protective equipment including face masks and gloves.

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.