General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Walderslade Surgery, High Croft, Hoyland, BARNSLEY, South Yorkshire, S74 9AF

Pharmacy reference: 1107707

Type of pharmacy: Community

Date of inspection: 29/05/2019

Pharmacy context

This community pharmacy is in a health centre in the village of Hoyland, Barnsley. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes and provides a flu vaccination service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 has adequate processes and procedures, so the team can manage the risks to its services. And it mostly keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns, so it can use the feedback to improve its services. The pharmacy generally keeps people's private information safe. It has adequate processes available to its team members, to help protect the welfare of vulnerable people. And the pharmacy team members know what to do if they have a safeguarding concern. The pharmacy's team members record some of the errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These procedures were set to be reviewed every two years. This ensured that they were still relevant and up to date. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs documented who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with. And they had all signed the SOPs. Which indicated that they had read and understood the contents.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist or the accuracy checking technician (ACT) typically spotted the error and then made the team member aware of it. And then asked them to rectify it. A log was used to record details of the errors. The team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. The regular pharmacist analysed the near misses each month. And the findings were documented and discussed with the team. The team members said that they had made some errors in selecting the incorrect strength of Lumigan eye drops. The team members separated the different strengths on the dispensary shelves to reduce the risk of the errors happening again. The pharmacist said that the separation of the different strengths had reduced the number of these errors.

The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. It recorded the details of the errors on to an electronic reporting form and the form was sent to the superintendent pharmacist's team. The form was printed and filed for future reference. The pharmacy had recently delivered medicines to a person by mistake. The team were required to re-read the SOPs on the delivery of medicines. This was to ensure that they were aware of the correct process and their responsibilities.

The pharmacy had a notice in the retail area which detailed how people could make a complaint. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The results of the 2019 survey was displayed in the retail area and were generally positive.

The team reported that the time they took to dispense prescriptions was seen by many people as an area of practice that needed improving. To achieve this, the team ensured that they used red baskets to hold prescriptions that needed dispensing immediately. And they ensured they gave people a realistic projected wait time, so they could better manage people's expectations.

The pharmacy had up to date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacists did not always record the times that their duties ended. This is not in line with requirements. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained and audited every month. A random CD item was balance checked and verified with the running balance in the register (Dexamphetamine 5mg X 56). A CD destruction register was maintained to record patient returned medicines. And it was complete and up to date. The pharmacy kept private prescription records in a register, which was complete and in order. The pharmacy had not supplied any medicines in an emergency. And so, no records were available for inspection. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy had an information governance (IG) policy in place. It contained information on how the team should protect people's information and data. The team members were clear of the importance of protecting the confidentiality of the people the served. The team were trained on how to handle private information and had a working knowledge of data protection requirements and General Data Protection Regulation (GDPR). A privacy policy was on display in the retail area. The pharmacy stored confidential waste in a separate area of the dispensary. The waste was then shredded.

The pharmacist on duty and the ACT had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had not trained. The team members gave several examples of symptoms that would raise their concerns. The team had access to the local safeguarding board's contact details. The team members had access to a safeguarding folder. The folder contained documents that the they could refer to. For example, a list of the signs of abuse and a document named 'what to do if you are worried that a child is being abused'. The team said that if they had a concern they would refer to the pharmacist on duty. And ask them to assess the concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to their own needs. But the team only complete training ad-hoc. And so, the team may find it difficult to complete training regularly. The team members work well together and can share their ideas to improve pharmacy services.

Inspector's evidence

At the time of the inspection, the team members present were the full-time resident pharmacist, a full-time trainee pharmacy assistant, a full-time accuracy checking technician (ACT) and a full-time trainee pharmacy technician. Other team members who were not present included five part-time pharmacy assistants and a deliver driver. The team members often worked overtime to cover both planned and unplanned absences. They were not permitted to take time off in December, as this was the pharmacy's busiest period. The ACT was also the pharmacy supervisor and took on many of the administrative responsibilities. Such as organising the staff rotas.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy did not provide its team members with a structured process for ongoing learning. But it supported the team members to undertake training by giving them time to read trade press material sent to the pharmacy. The team members could tailor their learning to their needs. The trainee pharmacy assistant had recently requested additional training on over-the-counter medicines. This was to ensure she knew the active ingredients of the medicines, their age ranges and which conditions they treat. The assistant was able to spend time to read the packaging of medicines. And was given ample opportunity to ask the pharmacist any questions.

The team members attended a team meeting which was held every one to two months. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. The team discussed patient safety and talked about any errors openly and honestly. They could suggest ways to make improvements to the service provided. But the team were unable to give any examples.

The team members received a performance appraisal each year with the pharmacy's supervisor. The appraisals were an opportunity for the team member to discuss what they enjoyed about their job and what they wanted to achieve in the future. They were set goals to achieve by the time the next appraisal took place. A pharmacy assistant said that she was recently asked to help other team members use the computer systems more efficiently.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required.

The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team said that they did not feel any significant pressure to achieve the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was generally clean, hygienic and well maintained. Floor spaces were mostly clear, with no obvious trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC and a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance.

The lighting was bright, and the temperature was comfortable throughout inspection. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it provides its services safely and effectively. It doesn't always store its liquid medicines correctly. And so, it cannot be certain that these medicines are fit for purpose when they are supplied to people. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. The team takes some steps to identify people taking high-risk medicines. And it provides them with advice when necessary.

Inspector's evidence

The pharmacy had level access from the health centre car park which led to the entrance door. A push button bell was affixed next to the entrance door. It was to be used to gain the attention of the team if a person needed assistance accessing the premises. But the bell was not working. The pharmacy advertised the services it offered via a display in the front window. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. Several healthcare related posters were displayed in the retail area.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people's prescriptions from getting mixed up.

The team occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to information cards about the programme that they could provide to people. The team completed an audit to identify people that they regularly supplied valproate to. Five people were identified. These people were given advice by the pharmacist. The pharmacy used clear bags to store dispensed fridge and CD items. This allowed the team to do another visual check before the handed the medicine to the person. And they asked the person collecting to also check the item to ensure they were receiving the medicine they were expecting.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team were responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the

person's prescriber. The team recorded details of any changes, such as dosage increases and decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels and information which would help people visually identify the medicines. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of stock every three months and the team kept a record of the activity. The records were complete. No out of date medicines were found following a random check of the dispensary stock. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The date of opening was recorded on liquid medication that had a short-shelf life once opened. But a bottle of ranitidine that had been opened on 31 January 2019 was seen on a dispensary shelf. The medicine should not be supplied to people one month after it had been opened. A bottle of trimethoprim that should be stored in its cardboard container, was seen stored loose on a dispensary shelf. And so, the pharmacy could not be certain that these medicines were still fit for purpose. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software, installed scanners or a SOP available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and generally protect people's confidentiality.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children.

The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs. The medical fridge was of an appropriate size. The medicines inside were well organised.

The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations. But the pharmacy stored some prescriptions and some bags of medicines sealed with people's addresses in the consultation room. And so, this information could be seen by people who used the room.

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.