General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Holme Lane, Cross Hills, KEIGHLEY, West Yorkshire, BD20 7LG

Pharmacy reference: 1109442

Type of pharmacy: Community

Date of inspection: 27/09/2019

Pharmacy context

This community pharmacy is within a health centre in the market town of Cross Hills. The pharmacy dispenses NHS and private prescriptions. It provides medication in multi-compartmental compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the 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	1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team pro-actively responds when people using the pharmacy services raise concerns.
		1.8	Good practice	The pharmacy team members have training and experience to respond well when safeguarding concerns arise. So, they can help protect the welfare of children and vulnerable adults.
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 identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has up-to-date written procedures for the team to follow. The pharmacy has suitable arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team responds well when people using the pharmacy services raise concerns. The pharmacy team members have training and experience to respond well when safeguarding concerns arise. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they usually act to prevent future mistakes. But they don't record all errors, or the actions taken to prevent errors. This means the team only has some information available to identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. All the team except one of the part-time trainee dispensers had read and signed the SOPs signature sheets to show they understood and would follow them. The signature sheets related to the role within the team, such as pharmacist or dispenser. The pharmacy had received electronic version of the SOPs for the Cohens off-site dispensing service. The team had not printed off the SOPs or signed them to show they had read these SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors. And the team member who made the error recorded their own mistake. A sample of the error records looked at found that the team had not made any records in August 2019. This was before the pharmacist manager started at the pharmacy. The records captured details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team printed off the report for reference. The report included details of the error and what contributed to the error. And the actions taken by the team to prevent the same error from happening again. Following an error with the wrong form of a medicine the team members had separated the two versions of the products. And they introduced a process of underlining the form on the prescription to act as a prompt to check the product they had selected. The team had put a note on the person's electronic record (PMR) to remind the team of the error. And to help prevent the team from making the same mistake with this person's prescription.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The team responded well to complaints raised by people.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy usually checked CD stock against the balance in the register. This helped to spot errors such

as missed entries. The pharmacy had recently changed the CD balance check to a Sunday. So, the regular pharmacist who worked on a Sunday was responsible for this task. And had the time to complete the balance checks. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. The records of private prescription supplies looked at found that the prescriber's details were not correct. The records of emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they mostly met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had completed training about the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. And it displayed a notice informing people that a privacy notice in line with the requirements of the GDPR was available on the Cohens website. Or the person could ask for a copy from the pharmacy team. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. And the pharmacy had an up-to-date procedure providing information on how to respond to safeguarding concerns. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017 and 2018. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy’s services. And the team members support each other in their day-to-day work. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. The team members discuss what they can improve on and agree new roles to help deliver the pharmacy's services.

Inspector's evidence

A pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy pre-registration student, a part-time pharmacy student, two full-time dispensers, two part-time dispensers, two full-time trainee dispensers, and two part-time trainee dispensers. At the time of the inspection the pharmacist manager, a Cohens management support pharmacist (MSP), two qualified dispensers and a trainee dispenser were on duty. The MSP was providing support for the pharmacist manager who had been in post eight weeks after moving from another Cohens pharmacy.

One of the full-time dispensers had recently enrolled on to an accuracy checking course. The other full-time dispenser helped with the delivery of medicines to people. This meant the dispenser could provide advice and answer people’s questions at the time of supply. Or contact the pharmacist for advice. The pharmacist manager invited one of the trainee dispensers who only worked weekends to attend the pharmacy during the week. So, they could experience more than they did on a weekend, as the pharmacy was quieter than during the week. And learn from the other team members.

The team held regular meetings. And team members could suggest changes to processes or new ideas of working. The pharmacy had a list of 10 key tasks developed by Cohens Head Office. The team had suggested using the list of keys tasks to develop a team rota. So, everyone knew how to complete these tasks. And completion of these tasks was not affected by team absence. The team had implemented this. So, each day the team allocated one team member a task such as covering the pharmacy counter. And there was also a team member in a floater role to provide support.
The pharmacy provided training for the team. But this was restricted to regulatory training. And it used a e-messenger to ensure all team members had up-to-date information. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And the pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it gets its medicines from reputable sources. The pharmacy team stores and manages medicines appropriately. The pharmacy manages its services well. And it keeps records of prescription requests and deliveries it makes to people. So, the team can deal with any queries effectively.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. One of the team gave a person asking about vitamin products good advice on the food products that contained the vitamins the person was asking about. The team used a template designed by a colleague from another Cohens branch to capture information for a diabetes audit. The information captured on the template included if the person had received a foot check or an eye check in the last 12 months. The team members recorded if they had referred the person for these checks. The pharmacy provided the flu vaccination against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the authority to administer the vaccine.

The pharmacy provided multi-compartmental compliance packs to help around 170 people take their medicines. The team sent most of the packs to the Cohens offsite dispensary. Two of the team managed the supply of the packs provided by the pharmacy. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a computer system to send the prescriptions to the offsite dispensary. The pharmacist completed a clinical check of the prescription before it was sent to the offsite dispensary. The system recorded the GPhC registration number of the pharmacist to identify who had completed the clinical check. And the pharmacist signed to show they had completed the clinical check. The dispenser recorded the date when the pack was due back. So, everyone in the team had this information if queries arose. And the team kept a record of the packs sent to the offsite dispensary in case of any queries. The team used a section of the main dispensary to dispense the medication in to the packs supplied from the pharmacy. The team members recorded when they had completed each stage of preparing the packs.

The offsite dispensary usually sent the completed packs back to the pharmacy three days after receiving the prescription. And it returned the packs in dedicated tote boxes. The team checked the tote boxes to ensure all the expected packs were supplied. And marked the packs to indicate if the person had a delivery. The offsite dispensary informed the pharmacy team of any items not dispensed by the offsite dispensary team. So, the pharmacy team dispensed and checked these medicines. The team stored completed packs in clear bags on shelves labelled with the person’s name and address. The pharmacy team recorded the descriptions of the medicines in the packs. And it supplied the manufacturer’s patient information leaflets. The offsite dispensary provided pictures of the medication in the packs.

But it did not send the patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team members checked the discharge summary for changes or new items. And they liaised with the GP team to arrange prescriptions when required.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses when the person presented at the pharmacy. Unless the person had a take away dose. These doses were prepared in advance of supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in a basket labelled with the person's name.

The team members provided a repeat prescription ordering service. They used an electronic system to remind them when they had to request the prescription. And used this as an audit trail to track the requests. The team usually ordered the prescriptions five days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team checked the system to identify missing prescriptions and chase them up with the GP teams. The pharmacy team worked closely with the three pharmacists based at the GP practice based next door. And the pharmacist manager had arranged a meeting with the practice manager to discuss delays with the receipt of prescriptions. The team were helping people who were experiencing delays with getting their repeat prescriptions. The team members took people's telephone numbers. So, they could call the person to update them with information or tell them that their prescription was ready.

The pharmacy used two box files to separate, in alphabetical order, the electronic prescriptions (EPS) printed off for dispensing. Previously the team members had put all the printed prescriptions in one basket. This made it difficult to find a prescription when a person presented or if there was a query. The team now used one box file to store prescriptions for labelling. And the other box file for prescriptions that had been labelled. The team members had a laminate card to mark where they had got to when labelling the prescriptions. So, whoever in the team returned to the box file to start labelling would know where to continue labelling from. And would not start the process from the beginning of the alphabet. The team provided people with clear advice on how to use their medicines. The team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). But the pharmacy did not have the PPP pack to provide people with information when required. The computer on the pharmacy counter had access to the electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries. If the person was not at home the delivery driver left a note informing the person of the failed delivery. The pharmacy had a dedicated section for failed deliveries, so the team could easily find them when the person came to collect it.

The team was tidying the stock on the shelves. And it was reducing the amount of stock held to help keep the shelves tidy. The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 23 September 2019. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Cetirizine oral solution with six months use once opened had a date of opening of 26 April 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team re-set the thermometer, re-checked the readings and regularly monitored the fridge temperature when the first reading was outside the range. But it did not keep a record of the second check to show the temperature was in range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had scanning equipment to meet the requirements of the Falsified Medicines Directive (FMD). But the team members hadn't received any training. So, they were not using the scanners. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it mostly protects people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had three fridges to store medicines kept at these temperatures. The pharmacy used one fridge for stock, another for medicines sold over-the-counter and the third for completed prescriptions waiting collection. The pharmacy completed safety checks on the electrical equipment.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. The pharmacy held most private information in the dispensary and rear areas, which had restricted access. But it kept some confidential information in the form of completed controlled drugs registers and private prescriptions on shelves in the consultation room. This room was not locked.

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.