

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, 37 Long Street, TETBURY,
Gloucestershire, GL8 8AA

Pharmacy reference: 1110365

Type of pharmacy: Community

Date of inspection: 03/11/2021

Pharmacy context

This is a community pharmacy in the historic Cotswold town of Tetbury, Gloucestershire. The pharmacy dispenses NHS and private prescriptions. It offers the New Medicine Service (NMS), seasonal flu vaccinations and a local delivery service. The pharmacy also supplies people with their medicines inside multi-compartment compliance packs if they find it difficult to take their medicines. The inspection was conducted during the COVID-19 pandemic.

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	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 is operating safely and largely complies with the company's policies. It has suitable systems in place to identify and manage the risks associated with its services. This includes the risks from COVID-19. Trained members of the team understand their role in protecting the welfare of vulnerable people. And the pharmacy protects people's private information appropriately. But it doesn't always record all the required information in some of its records. This could mean that its team may not have enough information available if problems or queries arise in the future.

Inspector's evidence

The pharmacy had recently taken over the business from another company. It was observed to be well-run during the inspection with competent staff. The pharmacy had suitably identified and continued to manage the risks associated with its services. This included limiting the spread of infection from COVID-19. The premises had been modified (see Principle 3). The pharmacy had information on display at the entrance asking people to wear a mask upon entering and about coronavirus. Members of the pharmacy team members were all wearing face masks. They had been vaccinated against COVID-19 and this included the booster dose. The pharmacy had hand sanitisers available. It was cleaned regularly. And risk assessments for COVID-19, including occupational ones for the team had been completed.

The pharmacy had a range of standard operating procedures (SOPs) to provide its team with guidance on how to complete tasks appropriately. The SOPs had been reviewed recently, and the staff had read and signed them. They also contained a matrix and details of individual team roles and responsibilities. This made each staff member's responsibilities clear. Members of the pharmacy team also knew what their tasks involved, they described being aware of the SOPs particularly when dispensing and the correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. In addition, the team had displayed a list of dispensing rules and professionalism in the dispensary.

The pharmacy had processes in place to record and learn from its mistakes. Staff explained that they used the prescription to select medicines against and generate dispensing labels. They described paying attention when dispensing and during the accuracy checking process. Team members also routinely recorded their near miss errors. The responsible pharmacist (RP) described recently implementing individual logs for the team so that they could document, monitor, and learn from their own mistakes more easily. The errors were formally reviewed every month and discussions held about them. Staff identified medicines that had been involved or where their packaging was the same and separated them. This helped prevent the mistake from happening again. Details of the pharmacy's complaints process was also readily available. The RP described handling incidents and complaints in a suitable way, this included investigating the situation, reporting the details, and discussing the mistake with other members of the team. He confirmed that there had been no dispensing incidents or formal complaints since his employment here.

The pharmacy team ensured people's confidential information was protected. The team used their own NHS smart cards to access electronic prescriptions. Confidential waste was separated and removed for disposal. And there was no sensitive information visible from or left in the retail space. The pharmacy's computer systems were password protected. The RP had been trained to level two to safeguard the welfare of vulnerable people through the Centre for Pharmacy Postgraduate Education (CPPE). All

members of the team could recognise signs of concern, they had been trained appropriately and staff referred suitably in the event of a concern. They were also trained as dementia friends. The pharmacy had contact details readily available for the local safeguarding agencies.

Most of the pharmacy's records were compliant with statutory and best practice requirements. This included a sample of electronic registers seen for controlled drugs (CDs), records of emergency supplies and records of supplies of unlicensed medicines. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had been maintained and records verifying that fridge temperatures had remained within the required range had been completed. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. There were also issues with the electronic register for private prescriptions as some details of the prescribers were missing or were incomplete. The pharmacy's professional indemnity insurance was through the NPA and due for renewal after 31 August 2022.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has plenty of staff to help manage its workload. Members of the pharmacy team manage the workload well. They are helpful and have completed the required training for their roles. And they are provided with appropriate resources for their ongoing training. This helps keep the team's knowledge and skills up to date.

Inspector's evidence

The pharmacy team consisted of the RP, who was relatively new to this employment, four full-time dispensing assistants, two part-time dispensing assistants, a pharmacy technician and two medicines counter assistants (MCAs). The pharmacy therefore had plenty of staff to manage its volume of workload and it was up to date with this at the inspection. Members of the pharmacy team were appropriately trained for their roles. Some of their certificates of qualification were seen. They felt supported and liked working at the pharmacy. One of the dispensing assistants had very recently completed the accuracy checking course. The paperwork for this had been sent for review and her role within the pharmacy was due to be actioned in due course. Both counter assistants knew what they could or could not do in the absence of the RP. They were knowledgeable about the medicines which could be purchased over the counter and asked appropriate questions before selling them. If they were unsure or if people requested more than one product, they always checked with the RP. Staff on the counter were also observed assisting people who used the pharmacy's services, provided one to one support and were known to people by name. Team members had access to resources for ongoing training. This was through the company's internal, on-line platform. Their performance was monitored, and they had regular meetings to discuss relevant points.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable to provide healthcare services. It is kept appropriately clean and tidy. The pharmacy has plenty of space to provide its services. It has a separate space where confidential conversations and services can take place. And it has maintained a suitable range of measures to help reduce the spread of COVID-19 inside its premises.

Inspector's evidence

The pharmacy was clean and tidy. A cleaning rota was in place to help maintain this. The pharmacy was also bright and suitably ventilated. An electronically controlled air conditioning unit assisted with this. The pharmacy premises consisted of a large retail area and a medium sized dispensary. There was also further dispensing and storage space at the rear. The latter held a suitable, segregated area to dispense multi-compartment compliance packs. Dispensing areas had enough space for the team to carry out this task safely and they were kept free of clutter. The pharmacy also had a signposted consultation room present for private conversations and services. The room was spacious which was suitable for the purpose it served. It contained hand washing facilities, appropriate equipment, and lockable cabinets. However, the door could not be locked, and a sharps bin was present. This was discussed at the time.

The premises had maintained the measures it had introduced at the start of the pandemic. This helped ensure social distancing and reduce the spread of infection inside its premises. Signs were on display indicating that face masks were mandatory inside the premises. The retail space had several chairs present which had been placed facing alternate directions, markers on the floor to indicate where people should stand and a one-way flow system in place. The markers helped several people to keep their distance from one another when using the pharmacy's services or waiting to be served. A screen had been positioned in front of the medicines counter as a barrier and a hand sanitising station at the entrance had been set up for people to use.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has organised processes in place. It obtains its medicines from reputable sources and stores as well as manages its medicines appropriately. And it supplies medicines inside multi-compartment compliance packs safely. But the pharmacy doesn't always identify people who receive higher-risk medicines and make the relevant checks. This limits its ability to show that people are provided with appropriate advice when supplying these medicines.

Inspector's evidence

The workflow in the dispensary involved staff preparing prescriptions in one area, the RP checked medicines for accuracy from another section and a designated space at the rear was used to assemble compliance packs. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer. They were also colour coded which helped identify priority. Once staff generated the dispensing labels, there was a facility on them to help identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy used licensed wholesalers such as AAH, Alliance Healthcare and the company's own warehouse to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were identified. There were no date-expired medicines seen. Dispensed fridge and CD medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This included sharps or needles provided they were in sealed bins. Counter staff could easily identify returned medicines which were hazardous or cytotoxic and the designated containers that they needed to be stored within. However, there was no list available to help guide them. Implementing this was discussed at the time. Drug alerts were received by email and actioned appropriately. Records were kept verifying this. The team was aware of the risks associated with valproates, these medicines had been placed in a separate drawer and highlighted to indicate the risks. Appropriate literature was available to provide to people at risk when supplying valproates. However, people prescribed other higher-risk medicines were not routinely identified, asked relevant questions or details about their treatment recorded.

The pharmacy was in the centre of the town and had local car parks in the vicinity. People could enter through a wide, automatic front door at street level and the retail space was made up of clear, open space. This assisted people with restricted mobility or using wheelchairs to easily enter and access the pharmacy's services. The pharmacy had some leaflets on display to provide information about various health matters, this included a notice board about healthy living and details about COVID-19. Few services were currently being provided. The RP administered the flu vaccine via a walk-in basis. He had been appropriately trained on vaccination techniques and resuscitation in the event of an emergency. Suitable equipment was present such as adrenaline in the event of a severe reaction to the vaccine. This helped to ensure that the service was provided safely. However, his signed patient group direction (PGD) and service specification were missing. The former was the legal mechanism which allowed the RP to administer this vaccine and should have been present at the pharmacy for verification. This was discussed and advised accordingly.

People's medicines were delivered to them and the team kept records about this service. Details were

obtained when people were in receipt of their medicines. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended. Some people's prescriptions were assembled offsite at the company's hub in Bolton. Once the prescription had been received, the RP carried out a clinical check, staff then processed the details for each prescription on the pharmacy system before the RP then accuracy checked the details. These processes could be easily verified because each prescription was stamped before the clinical check took place, the RP then initialled his details in the corresponding section of the stamp. The details were then submitted to the company's hub for assembly. When the assembled prescriptions were sent back to the pharmacy inside sealed totes, the team matched the details and confirmed that all of them had been received through scanning the barcode on each assembled bag through the company's internal system. This helped ensure no prescriptions were missing. Staff confirmed that there had been no complaints or issues with this service. Medicines which were owed were supplied in-house. The pharmacy also supplied some people's medicines inside multi-compartment compliance packs once the person's GP had identified a need for this. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Compliance packs were not left unsealed overnight, and all medicines were removed from their packaging before being placed inside them.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Its equipment is suitably clean. And the pharmacy takes extra precautions to help reduce the spread of infection when people use its facilities.

Inspector's evidence

The pharmacy's equipment and facilities were suitable for their intended purpose. This included current versions of reference sources, a range of clean, standardised conical measures for liquid medicines, counting triangles with a separate one for cytotoxic medicines, legally compliant CD cabinets and an appropriately operating pharmacy fridge. The dispensary sink for reconstituting medicines was clean. The pharmacy had hot and cold running water available. The consultation room was cleaned before and after being used for services due to the risks associated with the pandemic. Staff used cordless telephones for private conversations to take place if required and the pharmacy's computer terminals were positioned in a way that prevented unauthorised access.

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.