General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, New PCC, Hume Street, KIDDERMINSTER, Worcestershire, DY11 6SF

Pharmacy reference: 1113565

Type of pharmacy: Community

Date of inspection: 24/07/2024

Pharmacy context

This is a community pharmacy located next to a Medical Centre in Kidderminster, Worcestershire. The pharmacy dispenses NHS and private prescriptions. It sells over-the-counter (OTC) medicines and offers a few services such as the New Medicines Service (NMS), local deliveries and Pharmacy First. Most of the pharmacy's prescriptions are dispensed at the company's hub and delivered to the pharmacy for collection. This includes people who require their medicines inside multi-compartment compliance packs if they find it difficult to manage their medicines at home. A few people's medicines are also dispensed and supplied inside compliance packs at the pharmacy.

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	4.2	Good practice	The regular pharmacist actively and routinely works with the adjacent GP surgeries. This has led to an extension of the existing blood pressure testing service.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy manages its risks appropriately and members of the pharmacy team have access to written instructions to help them to work safely. They understand how to protect the welfare of vulnerable people and can safeguard people's confidential information appropriately. Team members deal with their mistakes responsibly. But they are not always documenting details when they review them. This could make it difficult for them to show that they regularly spot patterns and prevent similar mistakes happening in future. And the pharmacy could do more to make sure its records contain all the necessary details.

Inspector's evidence

The pharmacy largely suitably identified and managed risks associated with its services. Members of the pharmacy team understood their roles well and they knew what they could or could not do in the absence of the responsible pharmacist (RP). Team members generally had set tasks but rotated them when needed to efficiently manage the workload. People using the pharmacy's services could easily identify the pharmacist responsible for the pharmacy's activities as the correct notice was on display. Staff worked in accordance with the company's set procedures. This included current electronic standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The pharmacy also had an appropriate complaints and incident management procedure where any issues raised were dealt with by the RP.

Most people's repeat prescriptions were dispensed at the company's hub. Once the prescription had been clinically checked, labelled on the pharmacy system, and then marked as accuracy checked on the system, the details were submitted to the company's hub for assembly. Prescriptions were matched to the delivery once received which was usually the next day or within 48 hours. For these prescriptions, the RP undertook the clinical check and details were marked on the prescription. This helped identify that this stage had been completed. The accuracy checking dispenser (ACD) conducted the final accuracy-check and transmitted the details. The ACD was not involved in any other dispensing process other than the final check, and there was an SOP to cover this process. There were also clear lines of accountability between the pharmacy and the hub and staff knew what they were responsible for. The RP routinely carried out the final accuracy-check for people who attended the pharmacy and wanted to wait for their prescriptions. However, the inspector was told that due to delays with people's prescriptions returning from the hub, this meant that the pharmacy was frequently having to dispense them here instead when people arrived to collect their medicines. This had also led to a backlog of confidential waste to be disposed of.

The pharmacy's team members were observed to work in set areas. There was also a separate section for the pharmacist to undertake the final accuracy-check of assembled prescriptions which helped minimise distractions and enabled him to supervise retail transactions easily. The pharmacy's workspaces could have been tidier, but this was observed to be work in progress and was cleared as the inspection progressed. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were also colour coded which helped identify priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process.

Errors that occurred during the dispensing process (near miss mistakes) were also routinely seen to be recorded. Higher-risk medicines such as methotrexate were kept separate, look-alike and sound-alike medicines were identified, and 'fast-line' medicines were stored in a designated area. This helped reduce the chance of selection errors occurring. Staff described huddles taking place where they discussed frequent mistakes, and the RP undertook an annual patient safety report where all the relevant details were collated and analysed. However, the records used to document near miss mistakes had no details logged about the review which could help verify this process.

Staff had been trained to safeguard the welfare of vulnerable people. The pharmacist had been trained to level three and team members could recognise signs of concerns; they knew who to refer to in the event of a concern and contact details for the local safeguarding agencies were also easily accessible. The pharmacy's team members had been trained to protect people's confidential information. The team ensured confidential information was protected. No sensitive details were left in the retail area or could be seen from the retail space. Bagged prescriptions awaiting collection were stored in a location where personal information was not easily visible. People using the pharmacy's services were observed automatically standing some distance away from the medicines counter before being served. This helped promote privacy. Confidential information was stored and disposed of appropriately. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions.

The pharmacy had suitable professional indemnity insurance arrangements in place. The pharmacy's records were mostly compliant with statutory and best practice requirements. This included a sample of electronic registers seen for controlled drugs (CDs) and the pharmacy's CD destruction register which held details about CDs returned by people for destruction. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records about emergency supplies and unlicensed medicines had also been appropriately completed. However, incorrect, incomplete or on occasion, no details about prescribers had been documented within the electronic private prescription register. There were also some gaps within the RP record where pharmacists had routinely signed in but not always recorded the time that their responsibility ceased.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have a range of skills and experience. They work well together and are supported by the regular pharmacist. They can also progress and develop their essential training further. But the pharmacy delivers ongoing training in an unstructured way. This could affect how well the team conduct tasks and adapt to change with new situations.

Inspector's evidence

On the day of the inspection, the regular employed pharmacist was present, along with the manager who was an ACD, a trained dispensing assistant who was undertaking accredited training to become an ACD and two medicines counter assistants (MCA). One of the MCAs was also in training and enrolled on appropriate accredited training to support this role. There were another two dispensing assistants who were not working at the time of the inspection. This was a busy pharmacy due to the pharmacy's location. As most of the pharmacy's workload was dispensed at the company's hub, this meant that despite less staff being present, the pharmacy had an adequate number of team members to support the workload. The team confirmed that they could manage dispensing and routine tasks and the pharmacy was up to date with this. People were also observed to be served promptly.

Team members wore uniforms and name badges. They supported and assisted each other when required and the RP was very enthusiastic about pharmacy. He had ensured a good rapport and relationship existed between the pharmacy team and the adjacent medical centre. This meant that he routinely consulted with doctors and staff to ensure people received the best possible care. He was also enthusiastic about delivering the pharmacy's services (see Principle 4). The MCAs asked relevant questions before selling medicines and they referred appropriately. The company supported staff to progress and develop their training further. They could also complete formal training at work. Team members described learning about new topics or refreshing existing knowledge through the RP, reading trade publications and SOPs as well as access to some online resources. However, this was not delivered or monitored in a structured or regular way. Staff described receiving feedback from the RP, they could easily discuss concerns with him and had sat down with him to identify areas to improve the pharmacy's internal processes. However, team members had not had any formal performance reviews since their employment commenced. Team meetings were held as and when they were needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises present a professional image and provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean. And a separate space is available where people can have confidential conversations with the pharmacy team.

Inspector's evidence

The pharmacy was bright, professionally presented with modern fixtures and fittings. It had suitable ambient temperature and ventilation for storing medicines and safe working. The premises were secure from unauthorised access. The retail area was clean and tidy with several chairs for people to use while they waited. There was also a separate consultation room to hold private conversations and provide services. The room was of an adequate size and clearly signposted. The dispensary had an adequate amount of space for staff to carry out dispensing tasks safely. However, the stock room was quite cluttered. This included the backlog of confidential waste described under Principle 1 which needed destroying.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has an enthusiastic regular pharmacist who actively works with the neighbouring GP surgeries. This helps ensures people receive the best possible care through the pharmacy's services. Members of the pharmacy team help people with diverse needs to easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources, and it stores as well as largely manages them appropriately. Team members regularly identify people who receive higher-risk medicines and make the relevant checks, so they can take their medicines safely.

Inspector's evidence

People could enter the pharmacy from two entry points which included from the street and, or as they exited from the medical centre. Both entrances were step free and had automatic doors. The retail area consisted of clear, open space. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were approximately 15 chairs inside the pharmacy if people wanted to wait for their prescriptions and a car park with ample spaces available outside. The pharmacy's opening hours were displayed alongside a few posters indicating services provided. Staff could make suitable adjustments for people with diverse needs, they offered a separate area or the consultation room when required, spoke slowly and clearly to help people to lip read, used written communication if needed and representatives where possible.

The pharmacy also offered a delivery service for people who found it difficult to attend the pharmacy and the team kept suitable records about this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended. Most of the pharmacy's multi-compartment compliance packs were dispensed at the company's head office and sent back to the pharmacy for collection. A few people who had been identified as having difficulty in managing their medicines had their compliance packs assembled at the pharmacy. For both situations, 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. Descriptions of the medicines inside the packs were provided and all medicines were removed from their packaging before being placed inside the compliance packs. However, patient information leaflets (PILs) were not routinely supplied. This is a legal requirement and could mean that people were not provided with up-to-date information about their medicines.

Staff were aware of the additional guidance when dispensing sodium valproate and topiramate and the associated Pregnancy Prevention Programme (PPP). They ensured these medicines were dispensed in the original manufacturer's packs, that relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had identified people in the at-risk group who had been supplied sodium valproate. Team members routinely identified people prescribed medicines which required ongoing monitoring. They asked details about relevant parameters, such as blood test results for people prescribed these medicines, and routinely supplied the appropriate warning leaflets and cards.

People could have their blood pressure (BP) checked and their ambulatory BP could be monitored and checked over a 24-hour period through the pharmacy. However, this service had been extended and developed to a greater extent due to the efforts of the RP. He was routinely and actively working

alongside the adjacent medical centre. The RP explained that since his employment at the pharmacy, he had reached out to and had developed the relationship with the GP partners. This had enabled the pharmacy's services to become an extension of the two surgeries which were based inside the medical centre. Both surgeries now routinely referred people directly to 'Tom the pharmacist' for 24-hour BP checks through not only PharmOutcomes and directly via NHSmail but also through specific forms that the RP had created.

In addition, the RP worked directly with the hypertension specialist primary care network (PCN) pharmacist at the adjacent surgery. This was said to have led to multiple diagnosis of hypertension and the odd diagnosis of atrial fibrillation. In this way, the RP had helped develop the existing service further so that he was now actively involved with diagnosing hypertension, providing feedback on the ambulatory blood pressure monitoring (ABPM) results to people, following up through both the NMS service and at the pharmacy, as well as assisting with prescribing and deprescribing recommendations. Due to the elevated level of trust that the RP had built with people using the pharmacy's services and the medical centre, he could confidently recommend and guarantee an urgent appointment when needed. Positive feedback had subsequently been received from both the surgeries and people using these services. In response to the demand from the surgery, the pharmacy had increased the number of ABPMs it had. The RP also described routinely learning from his experiences and reflected on cases with the hypertension specialist pharmacist. His enthusiasm for proving services, engaging with, and motivating patients as well as effectively collaborating with other health care professionals were also noticeably clear to the inspector.

The pharmacy actively provided the Pharmacy First service. This was also in conjunction with the adjacent medical centre. The service specification and Patient Group Directions (PGDs) to authorise this were readily accessible and had been signed by the RP. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5).

The pharmacy obtained its medicines and medical devices from licensed wholesalers. Short-dated medicines were identified. The team checked medicines for expiry but kept limited records of when this had taken place. There were no date-expired medicines seen. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Records verifying that the temperature of the fridge had remained within the required range had been appropriately completed. Dispensed medicines requiring refrigeration and CDs were also 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. People who brought sharps back for disposal were redirected accordingly. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Team members generally keep them clean. And the pharmacy's equipment is largely used in an appropriate way to keep people's private information safe.

Inspector's evidence

The pharmacy's equipment included a legally compliant CD cabinet and appropriately operating medical fridges.
The pharmacy team had access to current reference sources, they could use standardised conical measures to measure liquid medicines and they had the necessary equipment for counting tablets and capsules. The pharmacy had hot and cold running water available although the dispensary sink for reconstituting medicines could have been cleaner. The pharmacy had suitable equipment to carry out the Pharmacy First service and to measure people's blood pressure. This equipment was said to be new. The pharmacy's computer terminals were password protected. They were also positioned in places where unauthorised access was not possible. The pharmacy had portable telephones so that private conversations could take place away from being overheard and confidential waste was suitably disposed of. However, team members did not always ensure their NHS smartcards were stored securely when they were not at work. This was discussed and advised at the time.

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.