General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Medforth Street, Market Weighton, YORK, YO43 3FF

Pharmacy reference: 1123165

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

The pharmacy is within a large medical centre in the small town of Market Weighton. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy offers the flu vaccination service. And it provides over-the-counter products via a minor ailments scheme. The pharmacy offers people free blood pressure checks.

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	2.5	Good practice	The team members support each other in their day-to-day work. The team regularly meets to share ideas and information. The team members identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.
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 has up-to-date written procedures that the team follows. The pharmacy has suitable arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy keeps most of the records it needs to by law. The team members have training, guidance and experience to respond well to safeguarding concerns. 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 the trainee pharmacy technician had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The trainee pharmacy technician had signed the previous versions of the SOPs. The signature sheets related to the team member's role, such as pharmacist or dispenser. 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 near miss errors. A sample of the near miss error records looked at found in some months there were less records than other months. The team recorded 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 team reviewed these records each month to spot patterns and make changes to processes. The pharmacy completed an electronic report for dispensing errors. These were errors identified after the person had received their medicines. The team sent the report to head office and printed it off for reference. The pharmacy had trained all the team to complete the report. So, completion of the report was in a timely manner. All the team members were informed of the error to learn from it. The team members recorded the error on the person's electronic record (PMR) to remind them of the error. And to help prevent the same error happening again to this person. The pharmacy undertook a monthly patient safety review. The trainee pharmacy technician led on this with support from one of the dispensers. The trainee pharmacy technician was also training one of the other dispensers to complete this. The results of the review were shared with the team members and displayed for the team to refer to. Recent reviews had highlighted to the team the low reporting of near miss errors. A recent review reminded the team members to take more care when picking strengths and counting medicines. And to double check their own dispensing before passing it to the pharmacist to check. The team attached labels to shelves holding items that looked and sounded alike (LASA). These reminded the team members to check the product they had picked.

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.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that some entries did not record when the Responsible Pharmacist finished their shift. The records of private prescription supplies looked at found that the prescriber's details were not always correct. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on 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. The pharmacist and pharmacy technician had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members had completed Dementia Friends training in 2017 and 2018. And they 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. It gives team members regular feedback on their performance. So, they can take opportunities to develop their career and keep their skills up to date. The team members support each other in their day-to-day work. They identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

Locum pharmacists covered the pharmacy opening hours. The pharmacy team consisted of a part-time pharmacy technician, a full-time trainee pharmacy technician, two full-time dispensers, one part-time dispenser, a part-time trainee dispenser and a part-time delivery driver. A new pharmacist manager was due to start. At the time of the inspection two locum pharmacists, the trainee pharmacy technician and two dispensers were on duty. The pharmacy provided training for the team. But this was restricted to regulatory training. The team members also accessed training when they identified a gap in their knowledge. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The full-time trainee technician had used the opportunity during a review to ask about the pharmacy technician training. This had been agreed and initially put on hold as the pharmacy had a full-time pharmacy technician. When the pharmacy technician reduced their hours, the trainee technician was offered the training. The trainee technician had also been offered and accepted the role of supporting four other Cohen's pharmacies in the area. The role involved visiting the pharmacy teams to provide advice and help when required.

The pharmacy held team meetings when there was information or incidents to be shared with the team. Team members could suggest changes to processes or new ideas of working. The team had changed the process of ordering stock. Previously the team members ordered stock each time they dispensed a medicine. But the team found this resulted in a large amount of stock. So, the team had worked out the daily usage of each medicine and wrote this figure on the shelf holding the medicine. Each day a team member counted the amount of stock and placed an order to maintain the quantity of stock at the level needed. This helped the team to keep the shelves tidy. And it had reduced the time taken to put the stock away when the delivery from the wholesaler arrived. The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. 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 was available 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 manages its services well. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately. The pharmacy team members keep records of prescription requests and deliveries made to people. So, they can deal with any queries effectively.

Inspector's evidence

People accessed the pharmacy via the step free entrance to the medical centre. 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. The pharmacy provided people with free blood pressure checks. One of the qualified dispensers who provided this service had worked for St Johns Ambulance. So, had experience of taking people's blood pressure and the appropriate advice to give when readings were outside the normal range. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the legal authority to administer the vaccine. The flu vaccination service was provided on limited days as only one pharmacist had authority to administer the vaccine. The pharmacy had adrenaline injections available in case someone had an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 50 people take their medicines. And to people living in a care home. The Cohens' offsite dispensary dispensed most of the packs for the pharmacy. 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. And it ordered the prescriptions two weeks before supply. The care home team sent the pharmacy team the repeat prescription requests three weeks in advance of the next cycle. So, the team had time to deal with issues such as missing items. And the dispensing of the medication in to the packs. 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. The offsite dispensary usually sent the completed packs back to the pharmacy three days after receiving the prescription. The offsite dispensary informed the pharmacy team of any items not dispensed by the offsite dispensary team. So, the pharmacy team could dispense and check 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 team sent the packs to the care home one week before the next cycle started. This gave the care home team time to check the medicines supplied and chase up any missing medicines. The pharmacy received information from the hospitals about people’s discharge medication. The team members checked the discharge summary for changes or new items. And they liaised with the team at the medical centre to arrange prescriptions when required.

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 a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The team asked people on high-risk medicines like warfarin for information such as their latest blood test results. But the team did not always record this information when it was given.

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 team members used this as a prompt to check what they had picked. 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 CD and 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 had a text messaging service to inform people when their repeat prescriptions were ready. The pharmacy team asked older people for a mobile number rather than a landline number as often the older person thought the call from the pharmacy was a scam. So, sending a text message to a mobile telephone would help as the person could identify the number as the pharmacy. 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.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a sticker to highlight medicines with a short expiry 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 morphine sulphate oral solution with 90 days used once opened had a date of opening of 04 November 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team kept notes of the action it had taken when the initial readings were outside the 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 baskets to separate CDs to help the team easily locate an item when dispensing. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team hadn't received any details of when the pharmacy would get the FMD systems. 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 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. The pharmacy had two fridges to store medicines kept at these temperatures. The fridges had glass doors to enable stock to be viewed without prolong opening of the door. The pharmacy team used a Suresign monitor to take people's blood pressure readings.

The 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. And it held most private information in the dispensary and rear areas, which had restricted access. But completed consent forms for the flu vaccination service containing people's confidential information were found in the consultation room. The team members locked the computer in the consultation room when it was not in use. And they used cordless telephones to make sure telephone conversations were held in private.

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.