General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Ground Floor, Globe Mill, Slaithwaite, Huddersfield, West Yorkshire, HD7 5JN

Pharmacy reference: 9011607

Type of pharmacy: Community

Date of inspection: 06/04/2022

Pharmacy context

The pharmacy is in a health centre in Slaithwaite, near Huddersfield. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes. The pharmacy provides seasonal flu vaccinations. The pharmacy moved to its current premises in September 2021. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not effectively assess and manage the risks with all of its activities. It does not have adequate governance arrangements to ensure team members complete activities in the safest and most effective way. This includes the way they store medicines, keep records and the changes the team makes following mistakes.
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 not all met**

Summary findings

The pharmacy doesn't have adequate governance arrangements in place to identify and manage all the risks associated with its activities. It has most documented procedures it needs relevant to its services. But team members have not read them. And they do not always follow them. Pharmacy team members suitably protect people's confidential information. And they keep the records they must by law. Team members discuss and record mistakes they make in the dispensing process. But they don't routinely make changes to prevent mistakes happening again. So, they may miss opportunities to learn and make services safer.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These procedures had been reviewed in July 2020. And they had been implemented when the pharmacy moved to its current premises in September 2021. There was a matrix at the front of the SOP file for team members to sign to confirm they had read and understood the procedures. But the signatures seen were from team members who no longer worked at the pharmacy. Current pharmacy team members, many of which were new team members, had not signed the matrix. And they confirmed they had not read the procedures since the pharmacy had moved or since they had started working at the pharmacy. Longer standing pharmacy team members could not remember when they had last read the SOPs in their previous pharmacy. The pharmacy had an SOP training booklet available for new pharmacy team members to complete. These team members confirmed they had not completed the SOP training booklet. Some of the ways of working in the pharmacy did not match the SOPs and introduced risk. These included the way team members responded to near-miss and dispensing errors, how they managed controlled drugs registers, and how they managed medicines expiry dates. Some of the shelves storing medicines were cluttered and untidy. There were several areas where different strengths of the same medicines were stored in the same stack of boxes, such as different strengths of co-amilozide. And there were areas where different medicines with similar names were stacked together and not properly separated. This included clonazepam, chlortalidone and chlorpromazine. This increased the risks of a near-miss or dispensing errors being made. The pharmacy defined the roles of the pharmacy team members based on their levels of qualification in a roles matrix. The pharmacy did not have a regular manager. This lack of effective leadership meant that often, basic governance and housekeeping tasks, such as making changes after errors were made, storing medicines safely and effective record keeping were not being completed properly. And this was introducing risks.

The pharmacy did not have a clearly documented procedure available about how to handle near miss errors made by pharmacy team members while dispensing. The pharmacy's SOP for accuracy checking referred people to a near miss error reporting process. But pharmacy team members could not find a documented procedure to reflect the details of this process. Pharmacy team members recorded their near miss errors on a paper record. And they sometimes thought about how to be more careful while they dispensed. But they could not provide any more examples of any changes they had made to make things safer after they had made an error. Their records provided little or no information about why mistakes had been made. Or the actions they had taken to prevent a recurrence and aid future learning. And there were no records available from previous months. Pharmacy team members did not analyse the errors they made to look for patterns. This was discussed. Pharmacy team members explained that without a managers' guidance, they found it difficult to decide on any effective changes

after they made a mistake. They explained that everyone had different ideas about the right changes to make after they made a mistake to help prevent it happening again. So, often no changes were made. Without available records, the inspector was unable to confirm if errors were being repeated. The pharmacy had been without a manager since January 2022. Pharmacy team members could not provide more comprehensive information about how they handled errors from before that date. They recorded dispensing errors that had been given out to people on the company's intranet system. They recorded what had happened. But they captured little information about why the error had happened. Or any changes they had made to make the pharmacy safer, other than discussing the error with the team members involved. In the examples seen, they attributed lack of a pharmacy manager as a cause of the errors. But they did not provide any information about why this had contributed to the errors.

Pharmacy team members explained that the pharmacy had completed a risk assessment to help them manage the risks of Covid-19 infection. But a copy of the documented assessment was not available during the inspection. Pharmacy team members were not wearing a face covering while they worked. After the inspection, the company explained they had allowed individual pharmacy teams to decide whether they wore face coverings at work. And this was because wearing a face covering was no longer a legal requirement. The pharmacy had provided a flu vaccination service to people during the 2021-2022 season. It had a file of information for team members. The file included a patient group direction (PGD) document and an SOP. But neither of these documents had been signed by the people who had delivered the service to confirm they had understood the information. And pharmacy team members present could not explain the service any further. They confirmed that the pharmacist who had delivered the service no longer worked at the pharmacy.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. But the process was not advertised to people in the pharmacy's retail area. Pharmacy team members explained that they were only notified of a complaint if they had been directly involved. And they would be asked about the circumstances and the reasons that had led to the complaint. They explained they did not discuss any learning from complaints or any changes they could make to prevent the same or similar complaint. The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers. It kept running balances in all registers. But pharmacy team members did not regularly audit these balances. And some were not accurate. Team members explained that auditing CD running balances was the manager's job. And because they did not have a manager, the task was not being completed. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record. And this was also complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register and electronically. Pharmacy team members were unsure about which register should be used. And they did not know how the pharmacy's SOP instructed them to record private prescriptions. This meant there was a risk that neither register was a complete and accurate legal record of the private prescriptions dispensed by the pharmacy. The pharmacy had dispensed one prescription recently that had no date written on the prescription. This meant the prescription was not legally valid when it had been dispensed.

The pharmacy kept sensitive information and materials in restricted areas. It segregated and secured confidential waste. And this was collected for secure destruction. Pharmacy team members explained how they protected people's privacy and confidentiality. The pharmacy did not have a documented procedure about confidentiality and data protection available in the pharmacy to help them achieve this. Pharmacy team members gave some examples of symptoms that would raise their concerns about vulnerable children and adults. They explained how they would refer their concerns to the pharmacist. But they were unsure about who else they could contact in the company to seek help or refer their concerns to. Pharmacy team members said they would use the internet to find information about local

safeguarding contacts. The pharmacy had a documented procedure explaining how team members should raise their concerns about children and vulnerable adults. But team members had not read the procedure. Pharmacy team members had not completed any formal training about how to protect vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members who are qualified for their roles and the services they provide. Pharmacy team members sometimes complete ongoing training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. But the pharmacy does not have a manager. And this means team members may not always have the right opportunities or guidance to learn and develop. Pharmacy team members feel comfortable making suggestions to improve the pharmacy's services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, three qualified dispensers and four trainee dispensers. The pharmacy's regional coordinator was present for part of the inspection. The pharmacy also employed a delivery driver. Team members were generally managing the dispensing workload, but they were not always completing some key processes or keeping all key activities up to date. Pharmacy team members explained they had not had a pharmacy manager since January 2022. And this was causing some issues with lack of effective leadership in the pharmacy. One example they gave was when someone made a near-miss error. Team members had previously discussed errors. And often, each team member would have a different opinion about the most effective change to make to prevent the same or similar mistakes in the future. They explained that because they could not agree, they did not make any changes to reduce risks and make the pharmacy safer. And this had also made them reluctant to discuss their mistakes with each other.

Pharmacy team members kept their skills and knowledge up to date by completing learning ad hoc. But they had not completed any training recently. Pharmacy team members explained they also discussed topics with each other. The pharmacy had formal appraisal process in place for pharmacy team members. An experienced dispenser explained they had not received an appraisal recently. And they could not remember when they had last received an appraisal. A trainee explained they had received an appraisal at the end of their induction period. And their current objective was to complete the necessary training to become a qualified dispenser. Pharmacy team members raised any personal knowledge and development needs verbally with the pharmacist or regional coordinator. And they felt supported by being signposted to relevant reference sources or by discussion to help address their needs.

Pharmacy team members explained how they would raise professional concerns with the regional coordinator or head office. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. They were less confident that their points would be considered by people outside their immediate team. Pharmacy team members had recently discussed the way they organised their prescription workload each day. This had resulted in them changing their filing system for prescriptions received each day. And the way they completed these prescriptions to make the process more efficient. A dispenser explained these changes had resulted in the team completing the work more effectively. And had reduced the number of times medicines were owed to people. The pharmacy had a whistleblowing policy. But pharmacy team members did not know how to access the company's whistleblowing system.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and well maintained. It provides a suitable space for the services provided. And it has appropriate facilities so people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. Most areas of the pharmacy were tidy and well organised. And the floors and passageways were free from clutter and obstruction. The pharmacy had a safe workflow in operation where prescriptions were prepared. And clearly defined dispensing and checking areas. It kept equipment and stock on an adequate number of shelves throughout the premises. But several of these shelves were cluttered and untidy, increasing the risks of someone making a mistake. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

The pharmacy had a clean, well maintained sink in the dispensary which was used for medicines preparation. It had a toilet elsewhere in the building, which provided a sink with hot and cold running water and other facilities for hand washing. The pharmacy provided team members with hand sanitiser in various locations to help them regularly maintain good hand hygiene. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area. Pharmacy team members controlled access to restricted areas of the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services. And it generally has processes to manage the risks associated with its services. Pharmacy team members provide up-to-date and relevant advice for people taking some high-risk medicines. And they adequately manage the systems in place for providing medicines to people in multi-compartment compliance packs. But pharmacy team members don't always follow the pharmacy's documented processes to help them identify and manage the risks to several key processes.

Inspector's evidence

The pharmacy had level access from the health centre car park and the surgery reception area. Pharmacy team members explained how they would support people who may have difficulty accessing the pharmacy's services. They explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels to help people with a visual impairment. A team member spoke Urdu and Punjabi as well as English. But they explained they rarely needed to communicate in these languages because there were few people in the local community that needed to communicate in Urdu or Punjabi.

The pharmacy provided medicines to people in multi-compartment compliance packs when requested. A good proportion of these packs were dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. And they annotated each printed prescription token to confirm these checks had been completed. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the completed sealed packs from the hub. Pharmacy team members married up the packs with the relevant prescriptions and any medicines that had already been prepared in the pharmacy to accompany the packs. The pharmacy provided each pack with an accompanying sheet attached which gave descriptions of what each medicine looked like, so they could be identified in the pack. A dispenser explained that people received information leaflets about their medicines when they were first prescribed. But leaflets were not routinely provided after that. Pharmacy team members documented any changes to medicines provided in packs on the patient's electronic patient medication record (PMR). They placed any completed packs in a holding area in the pharmacy while changes were being made. This helped to prevent packs being dispensed before the necessary changes had been made to people's medication.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels for medicines that were dispensed in the pharmacy. This was to maintain an audit trail of the people involved in the dispensing process. And they used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And he checked if the person was aware of the risks if they became pregnant while taking the medicine. He also checked if they were on a pregnancy prevention programme. The pharmacist was able to access information materials to give to people on the pharmacy's intranet to help them manage the risks. The pharmacy delivered medicines to people. It recorded the deliveries made. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. Pharmacy team members highlighted bags containing controlled drugs (CDs) to the delivery driver.

The pharmacy had a documented procedure for checking stock for short-dated and expired medicines. But this did not match the process being carried out by pharmacy team members. And team members confirmed they had not read the current standard operating procedure (SOP). The pharmacy did not have any records available of any expiry date checking being completed. When questioned, a dispenser explained that team members completed date checking approximately every three months. And some sections had been checked recently. But these checks had not been recorded. And team members could not confirm which areas they had checked and which they had not. Pharmacy team members highlighted medicines that were due to expire by attaching sticker to the pack. But they were unsure about how far in advance they highlighted these medicines. Several team members gave different accounts of how far in advance they would highlight a short-dated medicine, ranging from three months to twelve months. And they were unclear about when these medicines would be removed from stock. The inspector did not find any medicines that were out of date. Some of the shelves where medicines were kept were cluttered and untidy. One example seen was a shelf storing various look-alike and sound-alike medicines together, either next to each other or in the same stack of boxes. And some stacks had fallen over, mixing these medicines up further. This increased the risks of people making a picking error leading to a near-miss or dispensing error.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had some equipment available to help prevent the transmission of Covid-19. These included hand sanitiser and plastic screens. The pharmacy had a set of clean, well maintained measures available for medicines preparation. And it had facilities to collect and manage confidential waste safely and securely. It kept its computer terminals in the secure areas of the pharmacy, away from public view. And these were password protected. The pharmacy's fridge was in good working order. It restricted access to all equipment and it stored all items securely.

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.