General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cohens Chemist, Ground Floor left Suite (Unit 1), West Lodge, Station Approach, West Byfleet, Surrey, KT14 6NG

Pharmacy reference: 9012292

Type of pharmacy: Community

Date of inspection: 29/08/2024

Pharmacy context

This busy NHS community pharmacy is set in a commercial property next to a health centre in West Byfleet. The pharmacy opens five days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. It delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to have their blood pressure checked or get their flu jab.

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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work at the pharmacy talk about the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and agreed to follow them. And they knew what they could and couldn't do, what they were responsible for and when they might seek help. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist.

The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the RP. The pharmacy had reviewed its dispensing process. And most people's compliance packs or repeat prescriptions were now assembled off-site at one of the company's hub pharmacies. This meant the pharmacy team could spend more time talking to people about their medicines and deliver other services. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed the mistakes it made to learn from them and help stop the same sort of things happening again. It was required to record and review its mistakes and complete a monthly patient safety report to help it improve the quality and the safety of the services provided. But the most recent report, seen at the time of the inspection, was completed over five months ago. And it was unclear which team members were responsible for completing these reports.

The pharmacy had a complaints procedure. And details of how people could provide feedback about the services were included on the company's website. People could share their views and make suggestions about how the pharmacy could do things better. And some have left online reviews about their experiences of using the pharmacy and its services. The pharmacy team sent a text message to tell people when their prescription would be delivered following feedback. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept appropriate records to show which pharmacist was the RP and when. It had an adequately maintained electronic controlled drug (CD) register. And the stock levels recorded in the register were checked

regularly. The pharmacy kept a suitable record of the supplies of the unlicensed medicinal products (specials) it made. Its team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the details of the prescriber were sometimes incomplete or missing in the private prescription records seen. And the pharmacy team was reminded that an appropriate record needed to be made when it supplied a prescription-only medicine (POM) to a person in an emergency including the reason for making a supply even for requests referred to it through the NHS Pharmacy First service. The pharmacy team was also reminded that in addition to standard labelling requirements the words 'Emergency supply' needed to be added to the dispensing label when it supplied a POM to a person in an emergency.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. And the company's website told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy had policies on information governance. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. Members of the pharmacy team were required to complete training on data protection and safeguarding. And they knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And they can give feedback to help the pharmacy do things better.

Inspector's evidence

The pharmacy had a vacancy for a pharmacist to manage it and lead its team. The people working at the pharmacy throughout the inspection included a locum pharmacist (the RP), a trainee pharmacy technician, two dispensing assistants, a medicines counter assistant (MCA) and a trainee MCA. The pharmacy team consisted of two regular locum pharmacists, the trainee pharmacy technician, two dispensing assistants, two MCAs, the trainee MCA and a delivery driver. The pharmacy depended upon its team, locum pharmacists and colleagues from one of the company's other pharmacies to cover absences. And its team was supported by a Management Support Pharmacist and a head office team.

The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. Members of the pharmacy team, including the delivery driver, were required to complete mandatory training during their employment. And they had completed or were completing accredited training relevant to their roles. People working at the pharmacy could discuss their development needs and any clinical governance issues with the RP and each other when the pharmacy wasn't busy. And they were encouraged to learn from mistakes too.

Members of the pharmacy team didn't feel that any targets or incentives stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they were up to date with their workload. Team members knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And, for example, some handrails were installed outside the pharmacy following staff feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright and secure. And its public-facing area was suitably presented. The pharmacy had a counter, a dispensary, some retail space and a small staffroom. It had enough storage and workspace for its current workload. And it had a consulting room for the services it offered that required one or if someone needed to speak to a team member in private. The consulting room could be locked when not in use to make sure the things in it were kept secure. The pharmacy had the sinks it needed as well as a supply of hot and cold water. And its team was responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And it delivers medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. But it doesn't always give people the information they need with their compliance packs to take their medicines safely. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy didn't have an automated door. But its door was kept open and its entrance was level with the outside pavement to make it easier for people to access the premises and services offered. The pharmacy had a notice that told people when it was open. And it had a seating area for people to use when they wanted to wait. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with NHS Pharmacy First referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for some minor illnesses. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a local delivery service to people who couldn't attend its premises in person. And it kept a record to show the right medicine was delivered to the right person. The pharmacy provided winter flu jabs. And its team had started to prepare for the upcoming season. The pharmacy had the patient group directions and protocols it needed for the NHS Pharmacy First service. The pharmacy used a hub pharmacy to assemble some of its repeat prescriptions. It used another hub pharmacy to dispense people's medicines into disposable and tamper-evident compliance packs. But some compliance packs were still assembled at the pharmacy. The pharmacy team was responsible for the accuracy of the data entered into the computer for prescriptions dispensed at each hub pharmacy. And the pharmacist needed to make sure the prescription was clinically appropriate too. The pharmacy team told each person that their prescription may be sent to another pharmacy to be made up. And the assembled prescriptions were returned to the pharmacy for the team to hand out or deliver. The pharmacy team checked whether a medicine was suitable to be re-packaged. And an assessment was done to decide if a person needed a compliance pack. The pharmacy kept an audit trail of the people involved in the assembly of each compliance pack. And a brief description and/or a photograph of each medicine was printed next to the medicine's name. This made it easier for people to tell what medicine they were taking. The pharmacy team usually provided patient information leaflets (PILs) with the compliance packs it assembled. But PILs weren't routinely supplied with the compliance packs the hub pharmacy assembled. So, people didn't always have the information they needed to take their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD

prescriptions were usually marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully.

Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had access to the resources they needed when they dispensed a valproate. But more could be done to make sure the dispensing labels applied by the hub pharmacy didn't cover up any braille or important patient safety information on the medicine's packaging.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked some, but not all, containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But some cytostatic medication was found in a waste bin not intended for hazardous medicines. The pharmacy had a process for dealing with the alerts it received from the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described what actions they took and demonstrated what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out or count medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association as well as a team at its head office to ask for information and guidance. The pharmacy had the medical refrigerators it needed to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the Pharmacy First service as well as for measuring a person's blood pressure. And this equipment appeared to be well maintained. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.