

Registered pharmacy inspection report

Pharmacy Name: Boots, Cestria Health Centre, Whitehill Way,
CHESTER LE STREET, County Durham, DH2 3DJ

Pharmacy reference: 1029388

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This pharmacy is within a health centre in a residential area out of the town centre. It has a separate entrance. It dispenses NHS and private prescriptions. And offers advice on the management of minor illnesses and long-term conditions. It offers a range of services including flu vaccinations. And it provides a delivery service.

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	2.2	Good practice	The pharmacy encourages and supports the pharmacy team to learn and develop. And it engages its team members in regular learning to develop their skills and knowledge to help improve services.
		2.4	Good practice	Pharmacy team members are committed to working in an environment of openness and transparency. And they work together to support learning and development.
		2.5	Good practice	The pharmacy team members feel comfortable raising concerns and making suggestions to improve the running of the pharmacy. This helps support the safe and efficient delivery of the pharmacy services.
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 has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. The pharmacy keeps all the records as required, by law in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing prescriptions, high-risk medicines and controlled drug (CD) management. The company reviewed these and every quarter sent out some for the team to read. The team completed quizzes at the end to test their understanding. The most recent reviews had been on CD SOPs. The team could advise of their roles and what tasks they could do. There were also several other corporate checks undertaken weekly to manage the running of the pharmacy.

The pharmacy was small, with a compact dispensary. The dispensary had a long dispensing bench and team members worked at various locations on this. There were dedicated checking areas for the pharmacists, one for walk-in prescriptions. And one for other items, including CDs and more sensitive items. The team managed the space well. The pharmacy team members used tubs throughout the process to keep prescriptions and medicines together. The prescriptions for waiters were all assembled at one end of the dispensing bench.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team members had their own sheets. And recorded their near missies on these. Examples included carbamazepine with the quantity 84 instead of 56, thiamine 100mg with 100 instead of 56 and diclofenac 75mg with capsules instead of tablets. Some of the team members were good at putting down reasons, comments and actions. But others had little explanation or comments such as 'double check' or 'rushing'. The team were encouraged to complete any reasons as soon as possible. The recent monthly patient safety review had shown a number of quantity errors. And the team discussed the various pack sizes to try to improve on these errors. The patient safety champion reviewed the logs and completed the monthly patient safety report with the pharmacist. The monthly patient safety report had good information and learning points. The team had also undertaken an audit on the bagging of prescriptions where the team members signed on the bag label indicating they had made the appropriate count check. They discussed this at the monthly meeting to instil the importance of this task. In addition to the monthly team briefing, the team members also had regular 'check-in' conversations and discussed any near miss errors individually.

The pharmacy had a practice leaflet which explained the complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey. And displayed the results which were all positive. The inspection was in combination with dealing with a concern raised to the General Pharmaceutical Council (GPhC). The pharmacist was aware of the concern which had been a dispensing

error and related issues. The concern had been logged on the company system PIERS at the time the pharmacy became aware. And the pharmacist had fully reviewed the concerns. He had also shared this with the team. And they had discussed ways to minimise any repetition. The team members advised of a previous concern involving a hand-out. They had revisited the SOP and had used various tools such as the prompt card to serve as a reminder the team. The team discussed any concerns together at the monthly patient safety review meetings. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacists completed the responsible pharmacist records as required. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy team members checked CD stock against the balance in the register at each time of dispensing. This helped to spot errors such as missed entries. The pharmacy undertook weekly stock audits of CDs. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy kept special records for unlicensed products with the certificates of conformity completed. It kept records for private prescriptions electronically as required.

The pharmacy had the 'Boots Pharmacy Fair Data Processing' notice displayed. This provided information on the confidential data kept and how the pharmacy complied with legislation. The team had read General Data Protection Regulation (GDPR) information and completed e-Learning on this. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for offsite shredding. And kept records and any paperwork confidential. Safeguarding information including contact numbers for local safeguarding were available for the team. The team had completed training on safeguarding. If a team member had a concern about a child or vulnerable adult, they would discuss this with the pharmacist in the first instance.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy encourages the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy provides feedback to team members on their performance. The team members share information and learning to improve their performance and skills. They support each other in their day-to-day work. And they feel comfortable raising any concerns they have and can make improvements. And they agree new processes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

There was one pharmacist, one technician and seven dispensers who worked in the pharmacy. The dispensers worked a range of hours from 37.5 to 22.5 weekly. The technician worked 11 hours a week. The pharmacy had additional pharmacist cover two to three days a week. One day to cover the pharmacist's day off. And the other days as second pharmacist. The pharmacy was open Monday to Friday and closed on Saturdays but every second Saturday two of the team members came in to carry out tasks such as cleaning and they undertook some training. This was generally for four hours. The pharmacist advised it was good use of time due to the pharmacy being busy during the week. It was more efficient to do when the pharmacy was closed to the public. And there were less people in the small dispensary. The pharmacist also took a turn coming in.

Certificates and qualifications were available for the team. The pharmacy team undertook training on a regular basis with some mandatory training and other optional modules. The team members completed training on the company's e-Learning system and on 30-minute tutors. The pharmacy team were provided with time for training. The team undertook tests on topics covered in the training, each quarter. This ensured understanding of topics covered. The team received performance reviews which gave the chance to receive feedback and discuss development needs. One of the dispensers had expressed an interest in becoming a technician. And was on the waiting list for the course. She was keen to start. The pharmacist provided 'in the moment' feedback to the team members as anything arose.

The pharmacist advised it was a good learning pharmacy for dispensing. But little over-the-counter. And often team members would move on to other pharmacies after having completed their dispensing training. The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist, area manager or clinical governance lead. The pharmacist advised the clinical governance lead had supported him well in a recent concern raised. This allowed him to discuss the issue openly and benefit from his own reflection. And it provided discussion for the team to learn which improved the processes and service to people.

The dispensary team worked closely together, and the dispenser said they were encouraged to provide feedback about the pharmacy or make suggestions for improvement. The team had reviewed the owings process. And changed the way in which they used the quad stamp as the audit trail. They found this improved the checking process and identification of people involved in the owed supply. They also added a 'refer to pharmacist' laminate with each schedule 2 CD. They had discussed this and advised

that by referring to the pharmacist it served as an extra reminder to make the CD entry.

There was a whistleblowing policy and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The pharmacy team had targets for services such as MURs. The pharmacy focused on the target groups. These were achievable and done when they met the patient's needs.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for the pharmacy services it provides. People can have private conversations with a pharmacist or team member in the consultation room.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The team used the space well. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean. The team cleaned daily. And every other Saturday two members came in to undertake general cleaning when the pharmacy was closed. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. This was important with the limited floor space. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team promoted for use. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy team kept the consultation room locked when not in use.

The pharmacy had a small waiting area which housed a glass cabinet which the pharmacy kept pharmacy medicines in. People asked for assistance if they required any of these items. There was a gate between the waiting area and the dispensary. The team kept the gate shut to prevent unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy is accessible to people. And it displays some information about health-related topics. The pharmacy provides its services using a range of safe working practices. The pharmacy team takes steps to identify people taking some high-risk medicines. And they provide people with additional advice. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages its medicines appropriately. It takes the right action if it receives any alerts that a medicine is no longer safe to use.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a touch pad at the entrance for easy access. There was some customer seating. And there was a working hearing loop in place. The pharmacy displayed its services within the pharmacy. The hours of opening were on the door. The pharmacy displayed a practice leaflet with information relating to services and opening hours available for people to self-select. It had a local health zone. And currently displayed information on diabetes. It had a few other posters and leaflets on health-related matters such as the flu vaccination service and NHS 111.

The team signposted people to the other Boots in the town centre for other healthcare services. And products as they had limited storage space. And no retail area with the exception of a few products. The pharmacist advised that he was reviewing the items to keep in light of the new Community Pharmacist Consultation Service (CPCS). The CPCS service connected patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy as their first port of call. The referrals came from NHS 111. The pharmacist advised they checked the system twice a day to see if there had been any referrals. He had undertaken a few of the CPCS. One had been an urgent supply of a Ventolin inhaler. And he had referred one person back to NHS 111 so they could arrange for a doctor to speak to the person as there had been issues.

The pharmacy provided Medicine Use Reviews (MUR) and the New Medicines service (NMS). The pharmacy had undertaken around 160 flu vaccinations. Some people made appointments. And the team made these for the days when there were two pharmacists present. Other people preferred to walk-in for the vaccination. The pharmacy provided the smoking cessation with the vouchers. It provided the minor ailments service and Emergency Hormonal Contraception (EHC) through a Patient Group Direction (PGD).

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team used a quadrant stamp on the prescription to show that the pharmacist had completed a clinical check. It also showed who had labelled, dispensed, accuracy checked and handed out the items. The team members used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out. The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The CD stickers had a space to record the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. There was a selection of laminated

cards which the team used to add to the tubs during the dispensing process to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling. They also completed the pharmacist information forms (PIFs) with any required information such as to text once completed or if an MUR was suitable. The pharmacy team noted on PIFs if any of the items dispensed was one of the Look-Alike Sound-Alike (LASA) drugs. This highlighted the extra vigilance when dispensing and checking. The dispensers ticked and signed the PIF if they dispensed a LASA drug.

Some of the items for prescriptions for people were undertaken at the company's Dispensing Support Pharmacy (DSP). This process was relatively new. And before starting the pharmacy team members discussed the best way to manage it. They set up a designated DSP workstation. This was in a quieter area of the dispensary to avoid distractions. The DSP service was only used for complete prescriptions only. The team had set up a box which they put prescriptions in for a clinical and data accuracy check. And a box for prescriptions only requiring a clinical check. The dispenser advised changes for data accuracy changes included 2.5mls on a prescription. And the pharmacy inputter changed this to 'half a 5ml spoonful' as this would be on the label from the DSP. The items came back from the DSP in green dispensing bags. The deliveries from the DSP came with the usual stock deliveries. And came back in different tote boxes to the stock. So, the team could identify them and put them in to the retrieval system. Most of the team, except newer starters were able to do the data input. The members had all undertaken training through e-Learning, watched videos and completed a test at the end. The inputter checked the DSP report once they had entered everything to ensure the DSP had accepted all items. The dispenser advised sometimes the DSP rejected bulky items so the pharmacy would have to do these. The DSP sent back some part completed prescriptions and the pharmacy completed these.

When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They explained the information they provided to the 'patients in the at-risk' group. They had a pack with additional information leaflets and stickers. The pharmacy had undertaken an audit. And had about six people in the vulnerable group. The pharmacy had advised them all accordingly.

The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs. The team advised that since the pharmacy had started to charge for deliveries the number had fallen. But most people had been happy with the concept of paying. And happy to pay. The pharmacy tried to ensure all medicines went out at the same time to avoid multiple deliveries.

The pharmacy generally stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. But there were a few boxes with incomplete labelling. These were generally uncollected with inadequate labelling as stock, with no batch number or expiry date. The pharmacy had two refrigerators from a recognised supplier. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy was monitoring the suitability of space as they felt they may require an additional fridge. This was predominately due to stock of Fostair and its storage requirements. . The doctors were prescribing more of it. The pharmacy members texted people as soon they had dispensed the Fostair try to keep the fridge clearer.

The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf

prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. The pharmacy used recognised wholesalers such as Alliance and AAH. The team were aware of the Falsified Medicines Directive (FMD). They advised the company had delayed the roll out for the pharmacy. And expected to have systems in place in the first quarter of 2020.

The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. The pharmacist put any alerts received on the monthly patient safety review. And this ensured the team were all reminded of recent alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring opiates. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves and alcohol hand washing gel.

The pharmacy stored medication waiting collection in drawer and shelves where no confidential details could be observed by people. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private.

The computer in the consultation room was screen locked when not in use.

The computer screens were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations. And took the phone to a more private area if required.

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.