

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 1-2 North Street, FERRYHILL, County Durham, DL17 8HX

**Pharmacy reference:** 1029458

**Type of pharmacy:** Community

**Date of inspection:** 12/02/2020

## Pharmacy context

This is a community pharmacy situated in the town centre. The pharmacy dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. It offers advice on the management of minor illnesses and long-term conditions. The pharmacy delivers medicines to people's homes. And it provides a substance misuse service, including supervised consumption.

## 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
<b>1. Governance</b>	Standards met	1.2	Good practice	The pharmacy team members consistently record and learn from the mistakes they make whilst dispensing.
<b>2. Staff</b>	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.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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. They consistently record and learn from these. 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). These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing prescriptions, responsible pharmacist, high-risk medicines and controlled drug (CD) management. The pharmacy team members signed signature sheets once they had read the relevant SOP. The team completed quizzes at the end to test their understanding. The locum pharmacist advised he obtained SOPs through Boots portal and he had read and made a declaration saying this. 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 team read the company document the Professional Standards which provided information on topics such as the Look-Alike Sound-Alike (LASA) drugs. The team members signed this once read. They used laminated guides for reminders and reference for processes, such as hand out. This served as a reminder to check names, addresses and postcodes. The pharmacy had an information board with materials on health and safety and other information to assist in the running of the pharmacy.

The pharmacy was well organised. It had three computer terminals. The team had changed the workflow following the accuracy checking technician (ACT) no longer working at the pharmacy. The pharmacist had a designated checking bench and worked at the front bench. Generally, two dispensers worked at a rear bench and prepared the repeat prescriptions, ordering the stock. The next day the stock for the repeats came in separate tote boxes and the team placed this stock on to designated shelves. They then labelled the prescriptions selecting the stock from the shelves. The pharmacy team members used tubs and baskets throughout the process to keep prescriptions and medicines together.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these on a specific template. Examples included fluoxetine 20mg with 56 on the prescription and it explained that 30 plus 26 should have been provided but there had been 2 boxes each with 26 given. There had been an example with Forti juice with the quantity provided 4000ml and the quantity owed 5600ml. The ACT had previously reviewed the near miss errors and attended the weekly patient safety calls. Now all the team members were taking turns on the weekly calls. And they were sharing the completion of the monthly reviews with the pharmacist. The most common error recorded was quantity and the team members had discussed this and now circled the amount and put the quantity inside the flap on boxes for spilt boxes. They noted the quantity errors had gone down slightly. They had discussed taking care with data entry and to ensure they changed any abbreviations especially milligrams which ensured the dispensing label would be correct. The pharmacist had individual briefings with the team members and the team had a team briefing together as well. The team had placed the

LASA warning shelf alerts in various locations. And they used the 'Select it Speak it' as a check when picking items from the shelves. They had the LASA guides at the computer terminals for a reminder.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey. The previous results had been very positive. There was a formal complaints procedure and reporting process through the company's system PIERs (Pharmacy Incident & Error reporting System). The team all knew how to record incidents and errors. And they discussed these at the monthly review for any learning. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy checked CD stock against the balance in the register after each dispensing. This helped to spot errors such as missed entries. The pharmacy completed full CD stock audits weekly. 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 maintained an electronic register for private prescriptions with a few entries recorded as required.

The pharmacy displayed the company notice 'Pharmacy Fair Data Processing' on the confidential data kept and how it 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 organisations was available for the team. The pharmacist had undertaken level 2 Centre for Pharmacy Postgraduate Education CPPE training. If a team member had a concern about a child or vulnerable adult, they would discuss this with the pharmacist in the first instance. The team had had no concerns.

## 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.

### Inspector's evidence

There were two pharmacists and five dispensers who worked at the pharmacy. The two pharmacists worked two and three days respectively in the pharmacy. Once every second week the pharmacy had a second pharmacist for three hours. The pharmacist advised that this was good for catching up with tasks and particularly useful for contacting people for the New Medicine service (NMS). The pharmacy had previously had an accuracy checking technician (ACT) but was managing the workload with a change in systems and the flow. One dispenser who worked 30 hours a week was the pharmacy manager. The other dispensers worked 40 hours, 37.5 hours and two worked, 32 hours a week. The team were experienced with most having worked between ten to 25 years in the pharmacy.

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 through the Pharmacy School. Recent training had included 'HUG' which was how to deal with people. And the topics of constipation and nicotine replacement therapy (NRT). The pharmacy team undertook training in the pharmacy, with time given for this. The team undertook tests on topics covered in the training, each quarter. The team advised that after they had completed the tests, they were sometimes given some extra recommended reading. The training provided links to information which they could print off and read. This ensured their knowledge was up-to-date and they had a good understanding of topics covered. The team advised they ticked their record once they had undertaken any extra reading.

The team read the company newsletter, the Professional Standards. They completed any case studies included in this with a recent one being on children's medicines. And one on hand out never events. The pharmacy manager undertook appraisals and performance reviews which gave the chance to receive feedback and discuss development needs. The team explained they had 'checkout' conversation every quarters which allowed them time to feedback and discuss if there was any training they wanted to do. One of the pharmacists was doing the clinical diploma. The pharmacists advised they had undertaken the CPPE training pack on Sepsis and the LASA drugs.

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 pharmacy manager or pharmacists. There was a formal whistleblowing policy and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

## 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. It was fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The sink, benches, shelves and flooring were all clean. One member of the team tended to clean the front retail area. The rest of the team shared the cleaning and tidying in the dispensary.

The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit. Separate hand washing facilities were in place for the team.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team used. 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. Members of the public could not access the dispensary due to the layout of the counter. The team were aware of people in the pharmacy as a bell on the doors rang to alert them.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy is accessible to people. 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 gets its medicines from reputable suppliers. It adheres to storage requirements during the dispensing process. 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 were two entrances to the pharmacy. There was a touch pad at the entrances for easy access. There was a bell at the front door that people could ring for attention. The team members could observe the rear door from the counter and dispensary so they would assist people if they required help. The pharmacy had a ladder with the services listed. There was some customer seating. And there was a working hearing loop in place.

The pharmacy displayed a range of posters on health rated topics within the pharmacy. And it had a health zone with material on 'Change 4 life' and 'Think about what you drink?'. It displayed some local information for groups in the area. The hours of opening were on the door and the pharmacy advised when the pharmacist would not be present over lunchtime. The pharmacy displayed a practice leaflet with information relating to services and opening hours available for people to self-select. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. It kept the pharmacy medicines in a glass cabinet and the team assisted any people who wished to purchase these items. The cabinet had wording which stated, 'ask a member of the team'.

The pharmacy had completed the number of Medicines Use Reviews (MURs) for the year. The pharmacist advised she focused on the New Medicine service (NMS) and felt that it was more beneficial for people. She generally signed up between five to ten people each week. She followed these up by phone and picked up simple benefits for people such as rinsing their mouth out and general use of inhalers. She checked to see if people were benefiting from using their preventative inhaler and using their reliever inhaler less. The pharmacy had undertaken around 100 flu vaccinations. People had walked in for the service and it had worked well with the accuracy checking technician (ACT) present. The pharmacist advised that the pharmacy would require to review the service for the next season since the ACT no longer worked at the pharmacy. The pharmacy provided the Minor ailments service and it provided Emergency Hormonal Contraception (EHC) through the Patient Group Direction (PGD).

The pharmacy provided the Community Pharmacist Consultation Service (CPCS). People accessed the CPCS service through NHS 111 referrals. The CPCS linked people to a community pharmacy as their first port of call. This could be for either the urgent provision of medicines or the treatment or advice for a minor illness. The pharmacy had had a few referrals. The outcome usually resulted in a sale of medicine, advice or a medicine from the minor ailments scheme. It had provided some urgent supplies and recorded these as required, including in the private prescription record as an emergency supply.

The pharmacy offered a substance misuse service and provided this to around 20 people. Around 15 received methadone. The pharmacist made up the supplies weekly and undertook a register balance check before making up the supplies. Most people received their supply supervised on the day. The

team signposted to other healthcare services. It referred people to the other Boots pharmacy across the road if they required their medicines in multi-compartment compliance packs. And it referred people to the other pharmacy for the smoking cessation service and needle exchange.

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. They used the blue card in the retrieval system if the medication was a fridge line and red for CDs. 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. The team completed these. There was a selection of laminated cards which the team used to add to the tubs and baskets 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 LASA drug and had both strengths before. They put 'no message' if nothing had changed. This highlighted extra vigilance when dispensing and checking. The pharmacist signed the bag labels as part of her check of the name and address with the prescription.

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 had undertaken an audit and had no people in the at-risk group. They explained the information they provided and advised people previously had said 'you've told us this before'. They had guides and cards available. The pharmacy delivery driver used a pod for signatures for deliveries. The pharmacy kept a delivery record as an audit trail for the items which had left the pharmacy to go to people. The driver had a separate delivery sheet for controlled drugs.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had two refrigerators from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. 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 recorded these in a book. They took these off the shelf prior to the expiry date. The team members clearly 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, AAH and Phoenix. The team were aware of the Falsified Medicines Directive (FMD). And had partly implemented. They were scanning some items. They advised that around 90 per cent of items scanned with the bar codes. They advised they could alter the brands and they feedback any issues. They said that the system was waiting for the final part of the technology and equipment for scanning out.

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 members actioned these and kept records of the action taken. They discussed these at the monthly patient safety review meeting.

## 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 company system Boots Live. And had links to the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). They printed these off if require and kept a folder with some of the more commonly required ones such as amoxycillin. The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of clearly measures for measuring methadone. The team kept these in a separate location. It also had a range of equipment for counting loose tablets and capsules. The team members cleaned triangles after use. The team members had access to disposable gloves and alcohol hand washing gel.

The pharmacy stored medication waiting collection in the dispensary. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private. The computer in the consultation room was not often switched on and if it was it was screen locked when not in use. The computer screens in the dispensary 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.

### 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.