General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 57 Beveridge Way, NEWTON AYCLIFFE, County Durham, DL5 4DU

Pharmacy reference: 1029461

Type of pharmacy: Community

Date of inspection: 24/04/2024

Pharmacy context

The pharmacy is in a shopping centre in the town of Newton Aycliffe. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy provides services including the NHS New Medicines Service and the NHS Pharmacy First Service. And it offers seasonal flu vaccinations. The pharmacy team provides medicines to some people in multi-compartment compliance packs, which helps them to take their medicines correctly. And it delivers medicines to people's homes.

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	1.2	Standard not met	The pharmacy team does not regularly learn from and review its mistakes to make services safer. And team members do not know the processes to follow when things go wrong. This includes how to create new records or access existing records to help with learning and to identify changes needed to make services safer.
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 not all met	4.4	Standard not met	Not all pharmacy team members know how to access information relating to safety alerts and recalls. And they do not know what to do to make sure these alerts and recalls are actioned in a timely manner to protect people's safety.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

Pharmacy team members do not regularly learn from mistakes they make whilst dispensing. And the team does not review these mistakes to inform changes in ways of working to make them safer. Team members have up-to-date procedures to follow to help reduce risks with providing services. And they know what steps to take to help keep vulnerable people safe from harm. They keep people's confidential information secure, and they mostly keep accurate records required by law.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to help pharmacy team members manage risk with providing services. Team members accessed these via an electronic platform. This held a record of which SOPs the team member had read and when, as well as highlighting any that were outstanding. And the team completed quizzes to confirm their understanding of the SOPs.

Pharmacy team members knew there was a process of responding to the mistakes they made and identified during the dispensing process, known as near miss errors. And although they knew to correct these mistakes and make records the team did not know how to access past or active near miss records. The team was unable to provide any examples of learning that has come about because of previous near miss errors or provide examples of any changes made to the way they worked to make dispensing safer. There were no alerts seen on or near the dispensary shelving to alert the team to potential risks of error during the dispensing process. The pharmacy team was aware of the need to report mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Team members did not know how to make these records themselves. And they weren’t aware how to access previous records to demonstrate how they were learning from these types of mistakes.

The pharmacy had a documented procedure for handling complaints and feedback from people. There was information available for people in the retail area about how to do this. The positioning of this information was partially obstructed which meant that some people may not be able to see the full details. The importance of this information being clearly visible was discussed with the team during the inspection. The pharmacy had current professional indemnity insurance. The Responsible Pharmacist (RP) clearly displayed their RP notice, so people knew details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP.

A sample of legally required records were checked during the inspection, and they mostly met requirements with a few minor omissions. The RP log had one missing entry in the seven days prior to the inspection and the importance of accurate entries was discussed with team members. The pharmacy kept its private prescriptions records electronically within the dispensing system. Of a sample of records checked, one private prescription did not have a record in the private prescription register. The RP acted to rectify this during the inspection. A sample of the controlled drug (CD) registers checked met legal requirements. The team completed weekly checks of the running balance in the register against the physical stock. A random balance check against the quantity of stock was correct. The pharmacy kept a register of CDs returned by people for destruction.

The pharmacy had a documented procedure to help team members manage sensitive information and it kept sensitive information in restricted areas of the pharmacy safe from unauthorised access. Team members segregated confidential waste into designated bags which was shredded off site. They explained how important it was to protect people's privacy and how they would protect confidentiality. A small number of medicines bottles which were empty, but had labels containing people's names attached, were found in the pharmaceutical waste bin. These were removed by a member of the team when highlighted to them during the inspection.

The pharmacy displayed a chaperone policy outside of the consultation room. Pharmacy team members gave examples of signs that would raise concerns about vulnerable people. A team member discussed actions they had taken previously to liaise with a local GP surgery about a concern they had. They knew how to find information about local safeguarding contacts by using the internet. The team had completed internal safeguarding training for their role and the RP had undertaken their own training at level 3.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with suitable qualifications to deliver the pharmacy's services. Team members work well together, and they support each other in their day-to-day work. They complete regular ongoing training to develop their skills and knowledge. And they ask suitable questions and give appropriate advice when assisting people with their healthcare needs. But team members are not always fully supported to complete all tasks during periods of absence.

Inspector's evidence

The RP on duty was a locum pharmacist. They were familiar with the company's processes, and they were observed supporting other team members in accessing information and completing tasks during the inspection. On duty alongside the RP were four qualified dispensers. One of which mainly managed the dispensing of multi-compartment compliance packs done onsite. Another of the team was fully trained around this service, to provide cover for annual leave or unplanned absence. During the inspection, the team was without their regular pharmacist and trainee pharmacy technician who were absent. An accuracy checking technician had recently left too. The pharmacy received occasional management support from a pharmacy manager at another branch. The pharmacy was also supported by several company-employed delivery drivers, who also worked delivering medicines for other local branches. The team was seen to be working together to manage the dispensing workload, although struggled to complete some tasks that absent team members usually performed, including recording near misses.

Pharmacy team members completed learning activities through the company's electronic platform. They explained what their most recent learning had involved. The RP had completed some training to deliver the NHS Pharmacy First service, including face to face training in the use of an otoscope. Pharmacy team members gave examples of their limitations in knowledge and when they would involve other team members to help. They asked appropriate questions when selling medicines over the counter. They explained how they assessed requests to purchase medications and at what point they referred to the RP.

Team members provided an example of how good communication they had received from another local branch had helped them deliver their compliance pack service for people safely. The regular pharmacist shared any feedback and complaints with relevant team members, with a view to improving customer service and ways of working. Team members knew how to raise concerns if necessary. The pharmacy had a whistleblowing policy and details, including how to report concerns, were displayed in the staff area. Team members were aware that the pharmacy had performance related targets to achieve and this didn't affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, hygienic and overall are a suitable environment to provide services from. The pharmacy has a suitable consultation room to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises had a large retail area. The dispensary appeared an adequate size for the workload. There was also a designated area upstairs, used to prepare and store compliance packs. There was a toilet, with a sink which provided hot and cold running water and there were other facilities for hand washing. To keep the premises clean, the pharmacy had contracted a cleaner, who came in during the lunch period when the pharmacy was closed to the public. The pharmacy team members used a clean, well-maintained sink in the dispensary for the preparation of some medicines.

There was a defined professional retail area, with healthcare related items for sale. The soundproof consultation room allowed the team to have private conversations with people and provide services. It was constructed of glass, with a curtain to pull across which protected people's privacy. There was a physical barrier in use to prevent unauthorised access to the dispensary and other restricted areas.

The pharmacy team kept the work surfaces in the dispensary tidy and it kept floor spaces clear to reduce the risk of trip hazards. There was sufficient storage space for stock, assembled medicines and medical devices. The pharmacy generally kept its heating and lighting to acceptable levels. However, one of the fluorescent ceiling lights was not working. This was directly above the main rotary stock receptacle and prescription retrieval shelves within the dispensary. This may increase the risk of error when retrieving stock or completed bags of medicines. The importance of reporting this was discussed. The layout of the premises allowed effective supervision of staff and pharmacy activities.

Principle 4 - Services **Standards not all met**

Summary findings

Not all pharmacy team members understand how to access and process information about reported national safety alerts. So there is a risk people may receive medicines that are not suitable for them to take. The pharmacy generally manages the delivery of services safely and effectively. And it sources its medicines from recognised suppliers and stores them appropriately.

Inspector's evidence

The pharmacy had level access from the shopping centre to allow people with mobility difficulties to enter safely. There was a hearing loop to allow pharmacy team members to communicate with people who may require such assistance. At the time of inspection, the opening hours on the company's website and NHS.uk did not reflect that the pharmacy was closed to the public at lunchtime. This could cause people to have difficulty accessing services at these times. And the online reviews for the pharmacy appeared to indicate that some had experienced this.

The pharmacy had a documented procedure for managing the checking of expiry dates of medicines. Team members highlighted short-dated medicines when they conducted date-checking tasks. They checked different sections of the dispensary stock in order and recorded when the expiry dates of medicines in a section had been checked and by whom. This ensured that the team had an audit trail of expiry dates checked. The team also kept a record of any medicines due to expire in a given month and they checked the shelf and removed any expiring stock. Medicines with a shortened expiry date on opening were marked with the date of opening, to ensure that these were not given out beyond their safe usage window. The pharmacy kept unwanted medicines returned by people in segregated cardboard bins, while awaiting collection for disposal.

The pharmacy team dispensed prescriptions to a procedure that used plastic containers. These dispensing containers kept prescriptions and their corresponding stock separate from others. Pharmacy team members signed dispensing labels during dispensing and checking. This maintained an audit trail of team members involved in the process. The team used laminated cards to highlight if a prescription contained a fridge item, to ensure correct storage temperatures were maintained. The team was observed using other similar cards for prescriptions that contained higher-risk medicines. The purpose of these were to highlight those prescriptions to help ensure the RP was involved at handout, to provide any advice.

The pharmacy dispensed prescriptions to a significant number of people into compliance packs, to help them take their medicines at the correct times. Prescriptions were requested well in advance before the supply was due, to allow time to deal with issues such as missing items. The pharmacy used a record for each individual person in receipt of their medicines in these packs that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs. Team members received communications about changes to people's medicines and documented them clearly in a communications book, including who took the message and when so there was a full audit trail. And they documented on the communication record when the task was completed. The team recorded the descriptions of the medicines within the packs on the dispensing labels, so that people could identify the different medicines. People were provided with patient information leaflets monthly and warnings about medicines were included on the medicine's labels. So,

people had the necessary information to take their medicines safely.

The RP counselled people receiving prescriptions for valproate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They checked if people were on a pregnancy prevention programme and taking regular effective contraception. They did not keep records of these conversations, so there were no audit trails in case of queries. Team members were aware of the requirements to dispense valproate in the manufacturer's original packs. And they included a laminated card when dispensing a prescription for valproate. This was used to highlight to the team at the point of handout the need to speak with the person collecting the medication.

When the pharmacy could not entirely fulfil a prescription first time, team members created an electronic record of what was owed on the patient medication system. And they gave people a note detailing what was owed. This meant the team had a record of what was outstanding to people and what stock was needed. The team checked outstanding owings as a daily task, and the pharmacy appeared to be managing these well. The pharmacy provided a delivery service for some people. It kept records of deliveries to help resolve any queries. This included the delivery driver capturing signatures on an electronic device. Any failed deliveries were returned to the pharmacy the same day. Pharmacy team members highlighted any deliveries that required extra attention, such as those that contained a fridge item or controlled drug.

The pharmacy team members present during the inspection were not aware of how they received drug safety alerts or manufacturer’s recalls, as they had not previously been involved in the process. And they were not able to provide records of or any previous examples of such alerts to which they had responded. There is a risk in this pharmacy’s process that when some team members are absent that important safety alerts would not be acted upon effectively and in a timely manner, which could result in people receiving medicines that are not safe for them to take.

Team members monitored and recorded the temperatures of the fridge daily. These records showed cold chain medicines were stored at appropriate temperatures. A check of the thermometer showed temperatures within the permitted range. The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. Team members use the equipment and facilities appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had a range of hard-copy and electronic reference materials available, via the internet. There was equipment available for the services it provided which included an otoscope and blood pressure monitors. And it had clean CE-marked measures available which were clearly marked for use with water or liquid medicines.

The pharmacy had cordless telephones so that conversations could be kept private. The pharmacy's computers were password protected and access to people's records was restricted by the NHS smart card system. And computer screens were oriented in such a way to prevent the content displayed being in public view. The pharmacy team stored completed prescriptions and assembled bags of medicines in a restricted area, which protected people's confidential information on the prescriptions and labels on the bags.

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.