General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 28 Front Street, BEDLINGTON, Northumberland, NE22 5UB

Pharmacy reference: 1035822

Type of pharmacy: Community

Date of inspection: 30/07/2019

Pharmacy context

The pharmacy is on a high street in the centre of Bedlington. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. And, they offer services including medicines use reviews (MUR), the NHS New Medicines Service (NMS) and various vaccinations. They provide a substance misuse service, including supervised consumption. And, they supply medicines in multi-compartmental compliance packs to help people take their medicines safely.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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	4.1	Good practice	The pharmacy actively engages with other local healthcare professionals to provide services to meet the needs of the local community. This means people can access advice and treatment for minor ailments more easily.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks. The pharmacy asks people using the pharmacy for their views. And, it acts to improve the quality of services in response. The pharmacy protects people's confidential information. And, it generally keeps the records it must by law. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen. And, they read about mistakes that happen elsewhere to improve their practice. Pharmacy team members use this information to learn and reduce the risk of further errors. But they don't always use the information collected about mistakes to inform the changes they make. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the pharmacy superintendent reviewed them regularly. The sample checked were last reviewed in 2017. And the next review was scheduled for 2019. Pharmacy team members had signed to confirm they had understood the SOPs since they were last reviewed. The pharmacy defined the roles of pharmacy team members in each procedure. And, pharmacy team members allocated daily tasks by having discussions throughout the day. The pharmacy had up-to-date SOPs and signed documents for the vaccination services being delivered via patient group direction (PGD). And, it had a declaration of competence from the authorised pharmacist confirming their training was up to date. The pharmacy had a daily and weekly audit in place as part of its governance arrangements. Pharmacy team members completed a checklist as part of the audit, looking at various aspects of the pharmacy procedures. They tested the fire alarms, checked the Responsible pharmacist (RP) records, controlled drug (CD) security and that the pharmacy was protecting people's confidential information.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They gave reasons such as not double checking or similar packaging had caused the mistakes. And, their most common change after a mistake was to double check next time or to separate similarly packaged stock. The pharmacist analysed the data collected about mistakes every month as part of a patient safety review process. They analysed the data for patterns, but the analysis tended to focus on the medicines involved, the staff members making the mistakes and the type of error, such as wrong strength and wrong form. Pharmacy team members explained that they always tried to change things to prevent a mistake happening again. One example was a common error where staff picked ramipril capsules against prescriptions calling for tablets. They now highlighted the prescriptions for tablets to make the dispenser aware it was a prescription for the less commonly prescribed formulation. A dispenser explained they had seen a significant reduction in that type of error in the two months following the change. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system called PIERS. In the sample of records seen, pharmacy team members gave a clear description of what had happened and who had been involved. But, they did not record much information about the causes of the error or what had been done to stop it happening again.

Pharmacy team members used a system of “Pharmacist Information Forms” (PIFs) to communicate messages to the pharmacist that they had seen on the patient's electronic medication record. They recorded information such as whether the medicine was new to the patient or whether any changes had been made since the last time they received it. They also recorded whether the patient had any allergies or whether they were eligible for services, such as a medicines use review (MUR). The form had a blank box to write any further information that the dispenser thought the pharmacist should be aware of. For example, pharmacy team members wrote the name of any look-alike or sound-alike (LASA) medicines on the PIF. Once they had dispensed the item, they ticked the name on the PIF to confirm they had performed a check of their own work to make sure it was correct. Then, the pharmacist signed the PIF to confirm they had also checked that the correct LASA medicine had been dispensed.

The pharmacy team received a bulletin approximately every month from the company professional standards team, called ‘The Professional Standard’. This communicated professional issues and learning from across the organisation following near miss and error analysis. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred and any learning as a result. Pharmacy team members read the bulletin and signed the front to record that they had done so. They also discussed the case study at their monthly patient safety briefing and displayed the bulletin on a noticeboard for people to refer to later. One example of a change made after receiving a bulletin was the implementation of the processes to take additional care dispensing medicines that either ‘look alike’ or ‘sound alike’ (LASA). A list of the medicines was attached to each workstation and such medicines were also written on the pharmacist information form (PIF) to highlight the risk to all those involved in the dispensing process. Pharmacy team members attached ‘Select and Speak’ stickers to the shelves and drawers in front of LASA medicines. The sticker encouraged pharmacy team members to speak the name of the medicine as the read it. And, this helped to draw staff attention to the risks of the medicines when dispensing.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company’s complaints procedure. It collected feedback from people by using questionnaires. One example of a change after feedback received was to improve communication with people if the pharmacy owed them an item from their prescription. Previously, the pharmacy had stored the prescription until all items were in stock. But, some people had complained that they were running out of items while waiting. So, pharmacy team members now contacted people to find out if they wanted to wait for the whole prescription, or whether they wanted a delivery of the stock available, with the medicines owed to follow. A dispenser explained they had received feedback from people to say that the new approach was more helpful and convenient.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And, pharmacy team members audited these against the physical stock quantity weekly, including methadone. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily in two fridges. They kept private prescription records electronically, and the samples seen were complete. But, pharmacy team members did not always accurately record the date of the prescription and the date the prescription was supplied. They recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected by a specialist contractor and destroyed securely. The pharmacy team had been trained to protect privacy and confidentiality. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). Pharmacy team members assessed the pharmacy for compliance with GDPR during each clinical governance audit.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to the company's internal process, local safeguarding teams or the area manager to get advice. The process was displayed in the dispensary. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members completed mandatory training. Registered pharmacists and pharmacy technicians also completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They undertake training regularly. They reflect on their own performance, discussing any training needs with the pharmacist and other team members. And they support each other to reach their goals. Pharmacy team members feel able to raise concerns and use their professional judgement. They can discuss issues and act on ideas to support the delivery of services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists, a pharmacy technician and three dispensers. Pharmacy team members completed mandatory e-learning modules each month. The modules covered various pharmacy topics, including mandatory compliance training covering health and safety, customer service and information governance, and other health related topics. They also received and completed The Tutor training modules received on paper each month. These modules covered health related topics, such as new products and seasonal health conditions, for example summer health and vitamins and minerals. Pharmacy team member's knowledge of The Tutor modules was tested every quarter via an online quiz. The pharmacy had a yearly appraisal process. Pharmacy team members discussed their performance with the manager and were given the opportunity to identify any learning needs. They then set objectives to address their needs. A team member gave an example of a one of their objectives. She explained that she wanted to learn more skills to be able to carry out more managerial responsibilities. She said she was being taught by the pharmacy manager and by observing his interactions with other members of the team. And, she was being given the opportunity to practice managing the team in certain areas with supervision.

A dispenser explained she would raise professional concerns with the pharmacist or superintendent pharmacist. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And, the team knew how to access the policy. The pharmacy team communicated with an open working dialogue during the inspection. A dispenser explained how the pharmacist told her when she had made a mistake. They discussed the mistake and the likely causes, even though this information was not always recorded. And, they tried to make changes where possible to prevent the mistake happening again. Pharmacy team members explained a change they had made after they had identified areas for improvement. They explained how they had changed the process for managing repeat dispensing prescriptions to make sure they were ready when people came to collect them. They had implemented a tracker which helped them to easily identify when a prescription was due to be dispensed before the next supply, And, to keep track of when prescriptions needed to be ordered.

The pharmacy asked the team to achieve targets. Targets included the number of patients who nominated the pharmacy to receive their electronic prescriptions, the number of medicine use review and new medicines service consultations completed, and the number of prescription items dispensed. Pharmacy team members were rated for compliance with targets using a score card. They discussed progress amongst the team. And, felt the targets were achievable.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. The pharmacy had three separate dispensing areas that were used for different tasks. They used one to dispense prescriptions from people who were in the pharmacy, one to dispense repeat prescriptions they had received from the surgeries and one to prepare and dispense multi-compartmental compliance packs. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink with hot and cold running water and other facilities for hand washing. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy actively engages with other local healthcare professionals to provide services to meet the needs of the local community. This means people can access advice and treatment for minor ailments more easily. The pharmacy is easily accessible to people, including people using wheelchairs. It stores, sources and manages its medicines appropriately. And it has systems in place to help provide its services safely and effectively. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And, they provide these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed by steps from the street at the front of the building and by level access through an entrance at the back. It had a portable ramp available for people who could not use the steps. And, it had a bell at the front door, with a sign telling people how to get the attention of a pharmacy team member if they needed help. But, the bell was not working during the inspection. And, there was no bell or signage at the back door. The pharmacist explained how he had developed a referral system with the local GP surgery. He explained that he met with the surgery every quarter to discuss and issues the surgery had and to discuss collaborative working. During one meeting, GPs had told him they had noticed a significant increase in the volume of appointments being requested by people for minor ailments that did not require a GPs attention. So, they had developed a triage system and people were referred to the pharmacy if they were describing an ailment that could be dealt with by the pharmacist. When they arrived at the pharmacy, people had a consultation with the pharmacist. The pharmacist said he would then provide the necessary advice and treatment. Or, he would refer the person back to their GP for an expedited appointment, using a dedicated referral form, if their symptoms required further investigation or a treatment that was not available from the pharmacy. The pharmacist said the system had resulted in a significant reduction in GP appointments for minor ailments. And, easier and more efficient access to treatment and help for people with minor ailments.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels and signed in a quadrant printed on each prescription. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent people’s prescriptions being mixed up. The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take the medicines. And, pharmacy team members added descriptions of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines with each pack dispensed. And, they documented any changes to medicines provided in packs on the patient’s change record sheet.

The pharmacy team used various alert cards that were added to a prescription basket during the dispensing process. For example, one card alerted staff to the presence of a controlled drug on the prescription, others to there being warfarin or lithium on the prescription that required further advice or monitoring. Staff requested any monitoring information and the pharmacist then made a clinical decision and made a record of the information provided. Another example was a card alerting staff to the presence of a medicine for children under 12 years old and the need for further advice and counselling when the prescription was handed out. And, for the pharmacist to carefully check the dose prescribed. Pharmacy team members highlighted prescriptions for CDs with a sticker on the bag and on the accompanying pharmacist information form (PIF). And a CD alert card was attached to the bag, which also had the expiry date of the prescription written on. This included prescriptions for schedule 3 CDs such as tramadol. They stored dispensed CD and fridge items in clear plastic bags to facilitate a further check of the product against the prescription by the pharmacist and the patient as the item was handed out. The pharmacy team member handing the medicine out asked the patient to confirm that the product was what they were expecting.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, she said she would check if the person was aware of the risks if they became pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy had some printed information material to give to people and to help highlight the medicine during dispensing. Pharmacy team members asked people with prescriptions for warfarin for information about their latest blood-test and if they knew their current dose. They recorded the information. And the pharmacist considered the information provided. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They were aware that they were going to receive training on the subject but did not know when this would be. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. But the pharmacy didn't have the right scanners, software or SOPs relating to FMD and so was not legally complaint. The store manager said they were waiting for a new computer system to be installed later this year. And, he said this would then enable them to be fully compliant. A pharmacy team member gave a clear explanation of the protocols in place to make sure over-the-counter medicines were provided to people safely. They gave examples of restricting the quantity of co-codamol and pseudoephedrine they would supply. And they gave examples of requests for certain products they would immediately refer to the pharmacist. They were unsure about the maximum legal quantity of paracetamol they could supply in one transaction. But, they said they would always refer to the pharmacist is someone asked for more than two boxes at a time.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

The pharmacy delivered medicines to people using a hub driver based at another store. Delivery records were populated by staff and uploaded to driver's electronic device. Each run sheet was also printed and signed by the driver to confirm collection. Deliveries were signed for by the recipient on the driver's electronic device and records were held centrally. Records of receipt could be requested if necessary. CD deliveries were signed for on a separate, paper docket and records were returned to the

pharmacy after each delivery run.

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 available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The dispensary fridges were in good working order. And the team used them to store medicines only. Access to all equipment was restricted and all items were stored 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.