General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1 Station Street, BEDLINGTON, Northumberland, NE22 7JN

Pharmacy reference: 1035824

Type of pharmacy: Community

Date of inspection: 30/07/2019

Pharmacy context

The pharmacy is in a row of shops in Bedlington Station. 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) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption and needle exchange. And, they supply medicines in multi-compartmental compliance packs to help people take their medicines safely.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy 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 help improve their practice. Pharmacy team members use this information to learn and reduce the risk of further errors. But they don't always discuss or analyse why mistakes happen. And, they don't always fully implement company-wide governance systems. 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 a pharmacy technician who was accredited to perform a final accuracy check of prescriptions. The technician explained that they were able to check anything that had been clinically checked by the pharmacist first. The pharmacist confirmed they had performed a clinical check by signing on the prescription in a quadrant stamp. The technician and the pharmacist completed a self-declaration every year to reaccredit the technician's checking competence. And, the technician was subject to mandatory revalidation as part of their professional registration. The pharmacy had a daily and weekly audit in place as part of its governance arrangements. Pharmacy team members completed a checklist 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 and pharmacy technician highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members discussed the errors made. But, they did not discuss or record much detail about why mistakes had happened. They usually said rushing or not double checking the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time. The pharmacist or nominated patient safety champion analysed the data collected about mistakes every month. But, they did not analyse the data for patterns of causes. And, in the samples seen, similar patterns of mistakes had been documented for several consecutive months, for example frequent errors involving look-alike and sound-alike medicines. This suggested that pharmacy team members were not fully establishing why these mistakes were happening. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents on an electronic reporting system called PIERS. But, during the inspection, the pharmacy manager was absent, and the rest of the team could not access any records made. So, the inspector could not assess the quality of error response or recording. Pharmacy team members were clear about the process if they were informed of an error. And, they knew how to start a new record. They could not give any examples of any changes made after an error in the past.

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.

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, pharmacy team members wrote the name of the LASA medicines on the PIF to highlight the risk to all those involved in the dispensing process. 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. But, this procedure was not always followed. And, there were recurring errors with LASA medicines, identified in recent monthly patient safety reviews. 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 they 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. On example of feedback was the time taken to provide prescriptions. Pharmacy team members explained that they were now being more specific when managing people’s expectations about waiting times, particularly now the pharmacy was busier.

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 they were audited against the physical stock quantity weekly, including methadone. It 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. They kept private prescription records in a paper register, which was complete. But, they sometimes did not accurately record the date of the prescription. Pharmacy team members 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 local safeguarding teams or the area manager to get advice. 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 a locum pharmacist, a pharmacy technician, who was also an accuracy checker, a trainee pharmacy technician, two dispensers and a trainee dispenser. Pharmacy team members said the most impactful change to them from the closure of a nearby branch was the increase in the number of people with over-the-counter queries. And, this meant that pharmacy team members were having to spend more time at the pharmacy counter, distracting them from dispensing. The pharmacy was actively recruiting a full-time dispenser. This was discussed with the team. And, a discussion took place about whether the pharmacy was using the pharmacy team members available in the most efficient and effective way.

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. They then set objectives to address their needs. Pharmacy team members said their objectives in the past had been focussed on the team reaching targets set by the company. They said that any personal learning objectives were discussed. But, they addressed them informally with the manager or area manager. They were confident that both managers would help them to address their needs. But, they could not give any recent examples of objectives they had set.

A dispenser explained she would raise professional concerns with the pharmacist or area manager. 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. But they did not always discuss why the mistake had happened. So, this limited what could be learned and changed to prevent a recurrence. Pharmacy team members explained a change they had made after they had identified areas for improvement. They had changed the way repeat dispensing prescriptions were downloaded for preparing medicines provided in multi-compartmental compliance packs. They explained that prescriptions had previously been downloaded close to when the pack was due to be supplied, causing delays. Pharmacy team members now downloaded all prescriptions each week for the following week. And, they attached them to the relevant patient record ready for preparation.

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, their objectives at each appraisal were related to target compliance. Pharmacy team members 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 properly maintained. Most areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. But, some benches were cluttered with paperwork and baskets of prescriptions waiting for the pharmacist to check. Despite this, there was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. The pharmacy 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, which provided 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 is easily accessible to people, including people using wheelchairs. And, it has systems in place to help provide its services safely and effectively. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. And, they provide them with the information they need to identify their medicines. They identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely. The pharmacy sources its medicines appropriately and it mostly stores and manages them as it should. But, sometimes the pharmacy team members don't fully follow the procedures for checking the expiry dates of medicines.

Inspector's evidence

The pharmacy had level access from the street through a power assisted door. There was also a separate entrance, used by people who required substance misuse services. The pharmacy had a hearing induction loop to help people with a hearing impairment. And, pharmacy team members said they would also use written communication with someone with a hearing impairment. Pharmacy team members could produce large-print labels to help people with visual impairment.

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 packs, so people had written instructions of how to take their medicines. And, it added the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines with each pack. They documented any changes to medicines provided in packs on the patient's master record and in a communication book.

Pharmacy team members 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 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. 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 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. Pharmacy team members said they did not know when they would be able to fully comply with the requirements. But, they said it would coincide with the installation of a new medication records system sometime this year.

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. But, they did not record expiring items on a monthly stock expiry sheet, for removal during their month of expiry, as instructed in the documented procedure. So, there was a risk that items could remain on the shelves once expired until the next stock check. This was discussed, and the pharmacy technician gave an assurance that the monthly stock expiry sheet would be implemented, in accordance with company procedures. 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. The pharmacy team 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. Pharmacy team members 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.