General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 28-30 Bamburgh House, Manor Walk Shopping Centre, CRAMLINGTON, Northumberland, NE23 6QE

Pharmacy reference: 1035845

Type of pharmacy: Community

Date of inspection: 29/07/2019

Pharmacy context

The pharmacy is in a shopping centre in Cramlington town centre. 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. The pharmacy delivers medicines to people's homes.

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	1.2	Good practice	Pharmacy team members learn about mistakes that happen elsewhere to help improve their practice. They share their learning from their own mistakes and develop their knowledge of medicines to help reduce the risks they identify. And, they have controls in place to make sure the changes they make are effective.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides good access to a library of training modules. And pharmacy team members complete ongoing training regularly, which is relevant to their role. This keeps their knowledge and skills up to date. The team members plan their training in advance, so they have relevant knowledge when they need to use it.
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. Pharmacy team members regularly record and discuss mistakes that happen. They are good at using this information to learn and make changes to reduce the risk of further errors. And, they read about mistakes that happen elsewhere to improve their practice. Pharmacy team members identify risks in dispensing and they develop their knowledge of medicines to help understand and reduce these risks. And, they have controls in place to make sure the changes they make are effective. The pharmacy asks people using the pharmacy for their views. And, it makes changes to improve the quality of services after it receives feedback. The pharmacy protects people's confidential information. And, it generally keeps the records it must by law.

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 2018. And the next review was scheduled for 2019 and 2020. 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 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 mistakes on their own individual records. They also had a separate record sheet for recording errors made at the walk-in counter and errors made in the room where multi-compartmental compliance packs were prepared. Pharmacy team members said they had their own individual records to make sure they were all recording their mistakes. And, this helped to prevent information being missed. Pharmacy team members discussed the errors made. And, they discussed and recorded details about why a mistake had happened. The pharmacist or pharmacy technician analysed the data collected about mistakes in each of the logs every month as part of the monthly patient safety review process. The review analysed the data for patterns of type of error, such as wrong strength or quantity, and information about patterns of causes. Pharmacy team members then set objectives to help address patterns found and reduce the risk of recurrence. The objectives were displayed on the noticeboard. The pharmacist explained they made their objectives specific, measurable and realistic. And, this helped pharmacy team members be clear about what to do to make the most effective changes. The pharmacist explained that they reflected on the objectives set the following month to establish if they had achieved the intended outcome. The pharmacist also produced a colourful poster each month highlighting a 'Near Miss of the Month'. The poster highlighted a medicine that had been involved in a mistake the month before. It provided a description of the medicine, in terms that the whole team could understand and relate to. Pharmacy team members used

the poster to help them understand what the medicine was for and the impact a mistake could have. The pharmacist explained the poster was also used to have a discussion with the team to highlight the risks and potential impact of the error. 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 any 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 they read it. And, this helped to draw staff attention to the risks of the medicines when dispensing. The pre-registration pharmacist had created a list, called 'What They Do', for the LASA medicines. Pharmacy team members explained the list gave information about what each of the medicine was used for. And, this had helped them to better understand the consequences of making a mistake. Each Professional Standard bulletin was accompanied by a 'Drug of the Month' card. The pharmacy used the card to highlight a medicine. Medicines were often high-risk or had the potential to be involved in a dispensing error. The card used bullet points to highlight key points and to explain to pharmacy team members what the medicine was used for. It also gave pharmacy team members ways to change their practice to help prevent a mistake with the medicine. Pharmacy team members displayed the most recent card in the dispensary. The card on display during the inspection highlighted the risks of mistakes when a person receiving their medicines in a multi-compartmental compliance pack was transferred to another pharmacy.

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 and the company's online feedback system. One example of feedback was from a partially sighted customer who fed back to staff that posters on a blue background or with blue writing were difficult to see. So, pharmacy team members changed a sign

they had made to help the flow of people at the counter to a yellow background.

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. The pharmacy team monitored and recorded fridge temperatures daily in two fridges. They kept private prescription records electronically, which was 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 or local safeguarding teams 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

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They have access to a library of training modules. And they complete ongoing training regularly, which is relevant to their role. This keeps their knowledge and skills up to date. The team members plan their training in advance, so they have relevant knowledge when they need to use it. 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.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were three pharmacists, a pre-registration pharmacist, a pharmacy technician, five dispensers and a trainee dispenser. 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. Pharmacy team members also had a library of training modules they could use when necessary. A dispenser gave an example of revisiting a training module on cough and cold the previous autumn, to help her prepare for the winter cough and flu season. Pharmacy team members 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 she wanted to develop her skills as a Healthy Living Pharmacy Champion. She said she was achieving her objective with support colleagues. And, she was being given time to spend on the pharmacy counter to help her improve how she communicated healthy living information to people.

A dispenser explained she would raise professional concerns with the pharmacist, store manager 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 and the likely causes. 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 had introduced a Medisure Change docket into the process of preparing multi-compartmental compliance packs. They had noticed that changes to people's packs were not always being communicated effectively to different team members working on different shifts. So, the process was changed, and they now used the dockets to record all information communicated about a patient's medicines and their packs. Completed dockets were kept with the patient's master records for future reference.

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. The pharmacy had a limited amount of bench space available for the volume of work being carried out. But, there was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. The pharmacy was also scheduled for a major re-fit in the next eight weeks. It kept equipment and stock on shelves throughout the premises. Pharmacy team members used a separate room to prepare multi-compartmental compliance packs. 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. It stores, sources and manages its medicines safely. 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 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 had level access from the pedestrianised shopping area through automatic doors. Pharmacy team members were able to provide large-print labels and instruction sheets for people with a visual impairment. And, there was a hearing induction loop for people with a hearing impairment to use. 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. Pharmacy team members added the descriptions of what the medicines looked like, so they could be identified in the pack. And, they provided people with patient information leaflets about their medicines each month. The pharmacy team documented any changes to medicines provided in packs on the patient's master record. And, on a Medisure Change docket, which was kept with the patient's record once completed. Pharmacy team members explained that most changes were communicated to them from the GP in writing. They said that all communications regarding packs were documented in a communications book for future reference. And, whenever they made a change to someone's master record, the changes were check by a pharmacist, who signed the record to confirm the details were correct.

The pharmacy sent a proportion of its prescriptions to the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions sent to the hub were usually for regular repeat medication. And, people were asked for their consent before their prescriptions were sent to the hub. They explained they could not send prescriptions for certain items to the hub, such as controlled drugs (CDs) and medicines that required refrigeration. And, if one prescription item was unsuitable for the hub, all items on the prescription would be dispensed locally in the pharmacy. The pharmacist clinically checked all prescriptions that were to be sent to the hub. And, they signed each prescription token to confirm they had performed the clinical check. A dispenser labelled each prescription. The label data added by the dispenser was sent to the hub, with an electronic copy of the prescriptions, to be printed and attached to the items picked by the robot. The pharmacist also checked any prescriptions where the dispenser had manually changed the directions during inputting the information for the label. Pharmacy team members then filed the prescriptions to wait for the medicine to be returned from the hub three days later. Prescriptions dispensed at the hub were returned to the pharmacy in dedicated totes. Pharmacy team members checked all returned bags to make sure all items requested had been dispensed. They then placed the bags in the retrieval area ready for collection or delivery. The pharmacist explained that the pharmacy using the hub was still in an implementation phase. And, this meant she was currently opening all bags returned form the hub and performing and additional accuracy check of each item. The pharmacist reported any discrepancies found to the pharmacy superintendent's office. Pharmacy team members explained that prescriptions for hub dispensing were processed in the compliance pack

preparation room. They said this was because the room was away from the busy main dispensary and was quieter. So, this helped to reduce distraction and helped to prevent mistakes.

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 cabinet(s) 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.

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. The pharmacy team kept the contents of the pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in the fridges every day. And they recorded their findings. The temperature records seen were within acceptable limits.

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. The store manager said they were waiting for a new computer system to be installed later this year. And, she said this would then enable them to be fully compliant.

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 controlled drugs (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. Pharmacy team members used a

docket to record detail of any prescriptions items that could not be supplied by the manufacturer. They explained they used the docket to keep track of whether all the necessary steps and communication had been completed. And, to make sure the patients had been informed of developments and whether to contact their GP to arrange an alternative medicine. Pharmacy team members had created a sheet of information to use when handing out common antibiotics. The sheet listed the most common antibiotics dispensed. And, with each item, the list provided them with information about what it was commonly used for and the key counselling points to provide to people. They said this was to help people understand their medicines and to make sure they completed their course of treatment effectively.

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.