General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 30-32 Main Street, SEAHOUSES, Northumberland, NE68 7RQ

Pharmacy reference: 1035874

Type of pharmacy: Community

Date of inspection: 02/08/2019

Pharmacy context

The pharmacy is on a high street in the village of Seahouses. 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 emergency contraception. They provide a substance misuse service, including supervised consumption. And, they supply medicines in multi-compartmental compliance packs and in an emergency via the NHS Urgent Medicines Supply Service (NUMSAS). Pharmacy team members provide these services to the local community all year round. And, they provide services to a high volume of tourists during the summer.

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	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 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. But, the pharmacist had not signed the procedures to confirm her understanding. She said she had read and signed the procedures in another local branch. But, not since she had started working at this pharmacy. The pharmacy defined the roles of the pharmacy team members in each SOP. 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 own mistakes if they were available when the error was identified. If they weren't, the pharmacist recorded the error. Pharmacy team members discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. The pharmacy team member nominated as the patient safety champion analysed the data collected about mistakes every month. But, the samples of the analysis seen concentrated on quantitative analysis, such as how many errors had been made. Or, the quantity of different types of errors, such as wrong strength or wrong quantity. They did not analyse the information captured about causes of mistakes to help inform the changes they made to prevent a recurrence. Pharmacy team members discussed each analysis at a monthly patient safety briefing. And, they set actions to help prevent mistakes the following month. Commonly, they proposed actions such as to double check or to keep focussed while dispensing. They did not usually make more specific changes. Some examples of changes made after near miss included separating look alike or sound alike (LASA) medicines to help prevent picking errors. 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. The records seen were comprehensive. And, they gave some detail about the causes of errors and the team's proposals to change to reduce the risk of a recurrence. In the examples seen, some of the reasons given for the error were distractions from colleagues and helping people in the shop and on the telephone. This was discussed, and pharmacy team members said it was an ongoing problem. So, the discussion centred around ways to manage interruptions from dispensing when they can't be completely removed.

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 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. One example of a change made after receiving a bulletin was reinforcing the emergency supply of medicines procedure to the team. Pharmacy team members discussed the procedure. And, the importance of confirming the person’s identity properly and making sure the pharmacist was always involved in the process. The pharmacy manager carried out a health and safety risk assessment every year. The assessment audited various elements of health and safety in all areas of the pharmacy. The manager provided records of the latest assessment. And, there were no findings for improvement. She explained that if there were findings, they would be reported to the relevant head office department and an assessment would be made about the risks to people. She said this would determine how quickly the issue would be resolved, either by head office staff or external contractors. She also said that if there was an immediate danger to people’s safety, the issues would be resolved immediately.

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 piece of recent feedback in the last 18 months was the time it took pharmacy team members to provide a prescription. Pharmacy team members explained that they had since changed the staff in the pharmacy and were working hard to manage people’s expectations. They said they had received positive feedback from people about the changes made and the improvements to the pharmacy service.

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 electronically, which were complete. But, pharmacy team members did not always accurately record the date of the prescriptions in the samples seen. 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. Pharmacy team members sealed the bags when they were full. And these

were collected by a specialist contractor and destroyed securely. Pharmacy team members had been trained to protect privacy and confidentiality. They were clear about how important it was to protect confidentiality. And, the pharmacy had 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 said that if the person was a tourist and did not live locally, they would contact head office for 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.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a pharmacy technician 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. 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 said she wanted to become a more effective communicator within the team. She said she was making progress. And, colleagues and the pharmacist were supporting her to help her speak up when she was struggling and to more effectively delegate tasks to others.

A pharmacy team member 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 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. 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 properly maintained. All areas of the pharmacy were tidy and well organised. And, pharmacy team members kept the floors and passage ways free from clutter and obstruction. The pharmacy had a safe and effective workflow in operation. And, it had clearly defined dispensing and checking areas. Pharmacy team members kept equipment and stock on shelves and in drawers 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.

The pharmacy had a clean, well maintained sink in the dispensary used for medicines preparation. It had 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 make necessary checks and provide these people with advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street through a power assisted door. 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. 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 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. Pharmacy team members documented any changes to medicines provided in packs on the patient's master record. And, the documented all communications received about packs in a communications book.

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. 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.

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. The pharmacy provided supervised consumption of medicines to people on holiday in the area. The pharmacist explained that before she dispensed medicines on a prescription requesting supervision, she contacted the person's prescriber or previous pharmacy. And, this was to check the continuity of their previous doses before they arrived at the pharmacy. If the person missed three consecutive doses, the pharmacist contacted their prescriber for advice about suspending the prescription. And, she said she was able to refer people to other substance misuse services in Northumberland in an emergency. 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.

Pharmacy team members checked medicine expiry dates every eight weeks. And they recorded their checks. 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. Pharmacy team members responded to drug alerts and recalls. And, they quarantined any affected stock found ready for destruction or return to the wholesaler. Pharmacy team members recorded any action taken. And, their 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.

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 it had 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, it protected them with passwords. It stored medicines waiting to be collected in the dispensary, also away from public view. The dispensary fridges were in good working order. And, pharmacy team members 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.