General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 2 Dean Terrace, RYTON, Tyne and Wear, NE40 3HQ

Pharmacy reference: 1037635

Type of pharmacy: Community

Date of inspection: 04/03/2024

Pharmacy context

This is a community pharmacy in the village of Ryton in Tyne and Wear. Its main activities are dispensing NHS prescriptions and providing some people with medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a range of NHS services and provides a delivery service, taking medicines to people in their homes.

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's written procedures help manage risk so that team members can provide services safely and effectively. Team members record errors made during the dispensing process and make changes to help prevent a recurrence of the same or a similar error occurring. They keep the necessary records required by law and know to keep people's private information secure. They know how to respond to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These were reviewed by the company's superintendent (SI) pharmacist team every two years. Team members accessed them on an electronic platform where they were directed to review newly updated SOPs when they were released. And they completed quizzes to confirm their understanding of them.

The pharmacy recorded errors identified during the dispensing process known as near misses. The pharmacist recorded the details of the error on an electronic platform and had discussions with team members. The accuracy checking pharmacy technician (ACPT) completed a monthly review of the data produced from near misses to produce a "patient safety review". This captured details of near misses or incidents that had occurred during the month and they discussed the review individually with each team member. Medicines that looked-alike or sounded-alike (LASA) were stored in a separate area of the dispensary to highlight to team members that caution was required when selecting them. The pharmacy completed incident reports for errors that were not identified until after a person had received their medicine. These were recorded electronically and shared with the area manager. The pharmacy had a complaints procedure which was detailed in the pharmacy's practice leaflet. Team members aimed to resolve any complaints or concerns informally. If they were not able to resolve the complaint, they escalated it to the area manager.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And they knew which tasks could and could not take place in the absence of the pharmacist. The ACPT had discussed with the pharmacist what she was comfortable checking. They checked on the patient medication record (PMR) system that medicines had been clinically checked electronically by the pharmacist before completing the final accuracy check. The ACPT further explained there was a safeguard which meant that any prescriptions scanned into the storage area for completed prescriptions highlighted if the clinical check had been missed. The RP notice was prominently displayed in the retail area and reflected the details of the RP on duty. The RP record was compliant. The pharmacy had a paper-based register for recording the receipt and supply of its controlled drugs (CDs). The entries checked were in order, with some minor omissions of the wholesaler address for received medicines. Annotations to the register were completed clearly. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them. And the destruction of these was undertaken by a pharmacist and witnessed by a team member. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept electronic records for its supply of private prescriptions and kept associated paper prescriptions.

The pharmacy had a data processing notice in the retail area of the pharmacy which informed people of how their data was used. Team members received annual training regarding information governance (IG) and general data protection regulations (GDPR). The pharmacy kept confidential waste separately for collection and destruction. Team members had received formal training for safeguarding, with the exception of a trainee dispenser. However, the trainee dispenser knew of their responsibilities to safeguard vulnerable adults and children and indicated they would refer any concerns to the pharmacist. The ACPT discussed the requirements of the “Ask for ANI” scheme with the trainee during the inspection to ensure they knew how to respond appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members complete regular ongoing training to develop their skills and knowledge. They ask suitable questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy employed a part-time pharmacist and a relief pharmacist who covered the pharmacy's opening hours. Other team members included an ACPT and five dispensers, one of whom was a trainee. The pharmacy had a delivery service provided by delivery drivers who worked across different pharmacies in the company. Team members had either completed accredited training for their roles or were completing an accredited training course. The trainee dispenser's learning was overseen by the part-time pharmacist who acted as the tutor. And the trainee received protected learning time each week in order to complete the qualification training in a timely manner. All team members received frequent learning through an online platform. They were directed to this by alerts received on a company intranet and via the pharmacy manager. Team members were able to explain what their most recent learning had involved. The pharmacist had completed training to deliver the NHS Pharmacy First service, including face to face training in the use of an otoscope. And the ACPT had completed training to take people's blood pressure and administer influenza vaccinations. Team members received monthly newsletters from the SI's office which included shared learnings from other pharmacies in the company.

Team members were observed supporting each other and were seen referring to each other regarding queries. And they were observed working well together to manage the workload. Annual leave was planned in advance and any unexpected absences were managed by the team as long as they were short term. The pharmacy could ask the area manager for assistance if required and help could be sent from other pharmacies in the company. Team members received six monthly performance reviews. There was an open and honest culture amongst the team, and they felt comfortable to raise concerns with management if required. The company also had a whistleblowing policy and details of how to report concerns were displayed in the staff canteen.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist or gave advice for people to contact their GP. Team members also handed out separate warning cards to help people take codeine-containing medicines safely.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has suitable facilities for people requiring privacy when accessing the pharmacy's services.

Inspector's evidence

The pharmacy was comprised of a small retail area to the front and a split dispensary to the rear. And there was an upstairs room where the preparation of multi-compartment compliance packs took place. The pharmacy portrayed a professional appearance. There was a medicines counter with a barrier which restricted unauthorised access to the dispensary. Team members managed any lack of privacy at the medicines counter by asking people if they would prefer their conversations to take place in the privacy of the consultation room. The dispensary was split over two levels on the ground floor, with steps down into a lower dispensary. Team members managed the limited space well and there were different benches for the completion of different tasks. The upstairs room had suitable space for the workload. And there was a storage area outside the room where completed packs were kept. The pharmacist's checking bench allowed for effective supervision of both the downstairs dispensary and medicines counter. This allowed them to intervene in conversations at the medicines counter if necessary. Medicines were stored neatly on shelves and the dispensaries were kept tidy. The main dispensary had a sink which provided hot and cold water for handwashing and professional use. And toilet facilities were clean and had separate handwashing facilities. Team members ensured the pharmacy was cleaned on a daily basis.

The pharmacy had a lockable soundproofed consultation room where people could have private conversations with team members and access services from the pharmacist. The room had a sink with hot and cold water, two chairs and a desk and computer. The temperature was comfortable throughout and the lighting was bright.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members complete checks on medicines to ensure they remain fit for supply. And they generally supply people with all necessary information to help them take their medicines. Team members respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had an automatic door and level access from the street which provided ease of access to those using wheelchairs or with prams. It had a range of healthcare leaflets displayed in the consultation room for people to read or take away. Team members described referring people to another pharmacy in the company for services they did not provide, such as travel vaccinations. The pharmacy provided the newly launched NHS Pharmacy First service which was underpinned by patient group directions (PGDs) and were available in paper form for easy referencing.

Team members used baskets to keep people's prescriptions and medicines together and to prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Laminated cards were attached to prescriptions highlighting the inclusion of a fridge line, controlled drug (CD) or higher-risk medicine such as valproate. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. They supplied original packs to people in line with recently updated guidance. This included a person who received a multi-compartment compliance pack. A split pack of valproate used before the legislation came into effect was removed from the shelves during the inspection. Team members were observed making suitable checks when handing out medicines to people to ensure they had been issued to the correct person.

The pharmacy had a delivery service, taking medicines to people in their homes. People who received deliveries were called the day prior to attempted delivery to ensure the delivery day would be suitable. Team members produced a list of the deliveries for the driver and the inclusion of a fridge item or CD was highlighted. Any failed deliveries were returned to the pharmacy for the person to collect.

The pharmacy supervised the administration of medicine for some people. Team members managed the service by preparing the medicine on a weekly basis, so the medicine was ready for people to collect. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. It had increased the number of packs dispensed for people due to a closure of a nearby pharmacy in the company. Team members described the transfer of people's packs had been gradual over the last few months so the increase in workload was managed safely. They ordered people's prescriptions ahead of time so any queries were resolved before they were due to be prepared. Each person had a clear medication record sheet which documented the medicines and dosage times. Team members received communications about changes to people's medicines and documented them clearly in a communications book, including who took the message and when so there was a full audit trail. And they documented on the communication record when the task was completed. The ACPT completed the final accuracy check of packs after the pharmacist had clinically checked them. Team members provided some descriptions of the medicines so they could be identified. The PMR system allowed the descriptions to be added manually or team

members could hand write them. But some labels did not include descriptions for medicines such as co-trimoxazole. Team members explained these had been missed. People were provided with patient information leaflets (PILs) monthly and warnings about medicines were included on the medicine's labels, so people had the necessary information to take their medicines safely.

The pharmacy sourced its medicines from licensed wholesalers, and it generally kept medicines in original containers, except for one pack found which contained mixed batches of the same medicine and was removed during the inspection. Pharmacy only (P) medicines were stored adjacent to the medicines counter in a cabinet which ensured the sales of these medicines were supervised by the pharmacist. The trainee dispenser referred all requests for the sale of P medicines to a trained dispenser. Team members had a process for checking the expiry date of medicines. They completed checks on different areas of the dispensary on a monthly basis and signed to say this had been completed. The last checks were completed in February. Medicines with a shortened expiry date on opening were marked with the date of opening. A random selection of several medicines found one out of date medicine and one unmarked medicine going out of date at the end of March. Team members indicated they checked the expiry dates of medicines as part of their dispensing process. The pharmacy had two fridges to store medicines that required cold storage. Team members recorded the temperatures daily with records showing that the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls directly from the company on an online platform. The ACPT actioned them and informed team members about the alerts. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had a blood pressure monitor and ambulatory blood pressure monitor for use in the NHS hypertension case finding service, and otoscopes used in the NHS Pharmacy First Service. The pharmacy had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection in a way that prevented unauthorised access to people's private information. Confidential information was secured on computers using passwords. And screens were positioned in the dispensary and consultation room in a way that prevented unauthorised people from seeing confidential information.

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.