General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 34-40 Cheapside, BARNSLEY, South Yorkshire, S70 1RT

Pharmacy reference: 1039080

Type of pharmacy: Community

Date of inspection: 16/05/2019

Pharmacy context

The pharmacy is in a pedestrianised shopping area in the centre of Barnsley. It is open seven days a week. The pharmacy team mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. And, it offers NHS services including medicines use reviews (MUR) and the New Medicines Service (NMS). Pharmacy team members provide a stop smoking service and substance misuse service, including supervised consumption and needle exchange. And, they supply medicines in multi-compartmental compliance packs to people in their own homes. They provide emergency contraception, travel vaccinations for meningitis, hepatitis, typhoid, and rabies, via NHS and private patient group direction (PGD).

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. They complete a weekly audit of key governance and safety tasks. And they ask people using the pharmacy for their views. So, they can work in a safe way and provide a quality service to people. The pharmacy protects people's confidential information. And, it generally keeps the records it must by law. Pharmacy team members record and discuss mistakes that happen. They use this information to learn and reduce the risk of further errors. And they read about mistakes that happen elsewhere to improve their practice. But they don't always discuss or record enough detail about why these mistakes happen. So, they may miss opportunities to improve. The pharmacy team members know how to safeguard the welfare of children and vulnerable adults.

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 their understanding of the SOPs since they were last reviewed. The pharmacy defined the roles of the pharmacy team members in each procedure. The pharmacy had up to date SOPs and signed documents for the vaccination service being delivered via patients group direction (PGD). And, it had a declaration of competence from the authorised pharmacist confirming their training was up to date.

The pharmacist highlighted near miss errors made by pharmacy team members when dispensing. And, they recorded their own mistakes. The pharmacy team discussed the errors made. But, they did not discuss or record detail about why a mistake had happened. The pharmacy technician analysed the data collected about mistakes every month. They recorded their analysis and then discussed their findings with the pharmacist. And, they shared the analysis with the rest of the team at a monthly patient safety meeting. Pharmacy team members said a common error had been ramipril capsules being dispensed instead of tablets by mistake. In response, they now highlighted the formulation of ramipril on each prescription to highlight the risk when dispensing and checking. They had also separated medicines with similar names and packaging to help prevent mistakes when selecting medicines. 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 detailed. But, pharmacy team members captured little or no information about causes of errors. The pharmacy had a patient safety review notice board. It used the board to display information compiled from the most recent patient safety review and from information received in the professional standard bulletin about mistakes made elsewhere in the company.

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 any changes 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 also had a blank box to write any further information that the dispenser thought the pharmacist should be aware of.

The pharmacy had processes in place to take additional care dispensing medicines that either "look

alike" or "sound alike" (LASA) drugs. A list of the medicines was attached to each workstation and such medicines were also written on the PIF to highlight the risk to all those involved in the dispensing process. The pharmacy team also displayed the list of LASA medicines on the staff noticeboard with a list of what each medicine was used for. This was to help them understand the impact of making a mistake with any of the listed items. They had attached "Select and Speak" stickers to the shelves and drawers in front of LASA medicines. Some stickers were provided pre-printed to correspond with the published list of LASA medicines. Others were blank and were populated by the team after a mistake was made and discussed, for example hand written sticker in front of lisinopril and lercanidipine. Pharmacy team members write the name of the LASA medicine on the PIF. They ticked the name when they had dispensed the item to confirm they had checked and picked the correct medicine. And, the pharmacist ticked the PIF to confirm they had checked the name against the medicine dispensed.

The pharmacy team received a bulletin approximately every month from the company professional standards team, called "The Professional Standard", communicating professional issues and learning from across the organisation because of 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.

As part of the pharmacy's governance arrangements it had in place a weekly audit. The team completed a checklist looking at various aspects of the pharmacy procedures. They tested the fire alarms, checked the Responsible pharmacist (RP) records, checked controlled drug (CD) security and checked the pharmacy was protecting people's confidential information.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. The pharmacist explained a change they had made in response to feedback. This related to items missing from prescriptions because of manufacturing problems or ordering issues. Pharmacy team members now kept all prescriptions with missing items separately. And, they kept a record of when items had been ordered. They kept people up to date about delays with their medication. And, found out if they were running out of the item. So, they were able to contact the prescriber and discuss an alternative for the people if needed.

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 kept private prescription records electronically. But they did not accurately record the date of a private prescription if it was different from the date the prescription was supplied. They also recorded emergency supplies of medicines electronically. But, they often did not record the reason for supplying a medicine without a prescription. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

Pharmacy team members had been trained to protect people's privacy and confidentiality. They completed e-learning every year. 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 GDPR

compliance by using the daily and weekly clinical governance checklist.

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 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 every two years. 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 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 needs with the pharmacist and colleagues. And they support each other to reach their goals. The pharmacy team members feel able to raise concerns and use their judgement. They can discuss issues and act on ideas to support the delivery of services. But they don't always establish and discuss specific causes of mistakes. So, they may miss chances to learn from errors and make changes to make things safer.

Inspector's evidence

The pharmacy planned staff levels four to eight weeks in advance. It covered planned absences, such as annual leave, with other pharmacy team members working extra hours where possible. It managed unplanned absences amongst the team or by asking for staff from other nearby stores.

At the time of the inspection, the pharmacy team members present were a pharmacist, four dispensers and a trainee dispenser. Pharmacy team members completed mandatory e-learning modules each month. The modules covered various pharmacy topics. They completed a quiz two or three times a year testing their knowledge of the standard operating procedures (SOPs). They last completed a quiz in January 2019. If they failed a quiz, they would revisit the relevant procedures and would be supported by teaching from colleagues. 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 was currently focussing on using a communications book more comprehensively to help communicate information about multi-compartmental compliance packs to colleagues working at different times.

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. The dispenser advised he was told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why he had made the mistake. But, he would always try and change something 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 progress log to track prescriptions and preparation of compliance packs. They used the log to record when prescriptions were ordered, when they were received, when they had been labelled, when they had been assembled and when they were checked and ready to supply. The new log helped the team to plan the compliance pack workload and helped the whole team to establish which stage each pack was at.

The pharmacy asked the team to achieve targets. Targets included the number of patients who

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

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy also had a room on the first floor where it prepared 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 WC and 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 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 mostly 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 pavement 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 sent some prescriptions to the company's central dispensing hub to be dispensed. It obtained consent from people to have their prescriptions sent to another site for dispensing. And, it recorded that consent had been given. Pharmacy team members had been trained to identify and triage prescriptions that were suitable for off-site dispensing. The pharmacist clinically checked the triaged prescriptions. And, a dispenser generated labels for printing at the hub, then sent the prescription and labels to the hub electronically. They printed the prescription token and recorded their involvement on the quadrant. They filed the prescription tokens in a file to be checked in two days' time. Each day, a pharmacy team member retrieved the filed tokens for that day. And, they paired the tokens with the bags of dispensed medicines received from the hub and placed them in the prescription retrieval area ready for collection. Medicines were dispensed at the hub by a robot. For any items missed during the initial triage, the system identified those that could not be dispensed using the robot. This included split packs, fridge lines and controlled drugs. These prescriptions were returned to the pharmacy to be dispensed manually.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It provided descriptions of most medicines supplied on the packaging. But, not for every medicine. It 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 electronic record. And, any communication between the pharmacy and the person's GP was documented in a communications record book. Pharmacy team members made a new master record sheet every time a change was made. And, the old sheet was archived with a date when it was replaced.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels and signed 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 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.

The pharmacist counselled people receiving prescription for sodium valproate if appropriate. And, advised would check if they were aware of the risks to someone who may become pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy had some printed information material to give to people and to help highlight the medicine during dispensing. Pharmacy team members asked people with prescriptions for warfarin for information about their latest blood-test and if they knew their current dose. They recorded the information. And the pharmacist considered the information provided.

Pharmacy team members 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 the month before their expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or returned to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. 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). 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.

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

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone.

The pharmacy kept sensitive information and materials in restricted areas. It 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. And, it collected confidential waste in blue bags. The bags were sealed when they were full. And they were collected by a contractor and sent for destruction. The dispensary fridge was in good working order. And the team used it 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.