General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 147-149 Main Street, BINGLEY, West Yorkshire, BD16 1AJ

Pharmacy reference: 1039411

Type of pharmacy: Community

Date of inspection: 22/10/2019

Pharmacy context

The pharmacy is on a high street in Bingley town centre. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs), the NHS New Medicines Service (NMS) and seasonal flu vaccinations. They provide a malaria prevention service, sometimes in conjunction with Boots online prescribing service. And, they supply medicines to people in multi-compartmental compliance packs. The pharmacy also offers a substance misuse service.

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	2.2	Good practice	The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to keep their knowledge and skills up to date. They reflect on their performance, so they can set objectives to improve. And, they support each other to reach these learning goals.
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 their key governance and safety tasks. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. The pharmacy protects people's confidential information. And, it mostly 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. And, they don't always make changes to respond to the risks identified. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2017 to 2019. And the next review was scheduled for 2019 to 2021. Pharmacy team members had read and signed the SOPs since the last review. The pharmacy defined the roles of the pharmacy team members in each procedure. And, by pharmacy team members having regular discussions throughout the day about the tasks to be completed.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. And, they sometimes recorded brief information about the causes of the errors. But, this didn't always happen. A common cause of mistakes recorded was distractions. But, people had not been specific about what the distractions were. And, there was little evidence of anything being done to manage distractions to prevent future errors. A nominated pharmacy team member analysed the data collected about mistakes every month. And, the analysis was recorded as part of a monthly patient safety review. The information in examples seen discussed the patterns identified in the data collected about errors. But, the analysis did not always discuss or attempt to rectify the patterns found. One example was an increase in the number of quantity errors being identified since the introduction of product scanning as part of a new electronic patient medication records system. This was discussed with the team. And, they had already recently identified that pharmacy team members had sometimes becoming complacent, relying on product scanning to spot all errors. And, so sometimes not following their long-established manual safety checks. The pharmacy manager gave an assurance that he would work with the team to make sure they used product scanning in addition to their established patient safety procedures. 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. Pharmacy team members discussed mistakes that happened. And, they sometimes made changes to prevent them happening again. But, the records of errors seen did not give much detail about why the mistakes had happened or what had been done to prevent them recurring. And, some of the examples reported that interruptions and distraction had caused the mistakes. But, this information had not been discussed or explored further to help manage distractions and prevent them causing mistakes.

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 and whether any changes

had been made since the last time they received it. They also recorded whether the patient had any allergies and whether they were eligible for services, such as a medicine 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 were required to write the name of any look-alike and 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 had a list of LASA medicines attached to each workstation. Pharmacy team members attached "Select and Speak" stickers to the shelves and drawers in front of LASA medicines to highlight the risks during the dispensing process.

The pharmacy had a daily and weekly audit in place as part of its governance arrangements. The pharmacy manager 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. There were no findings for improvement in the recent examples seen. Pharmacy team members 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. One recent case study was about identifying and acting appropriately to prescribing discrepancies. Pharmacy team members read the bulletin and signed the front to record that they had done so.

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 online customer surveys. One feedback point was waiting times and people feeling they were being ignored at the pharmacy counter. The manager explained that this type of feedback had been most likely been given where pharmacy team members was serving someone else. And, while someone was waiting to be served further down the counter. The team had discussed the feedback and were now careful to acknowledge people as soon as possible, even if it was to ask them to wait a few minutes while they finished their current task.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And, these 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. But, in some of the samples seen, they did not accurately record the date on the prescription. They recorded emergency supplies of medicines electronically. Pharmacy team members 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 Regulation (GDPR). Pharmacy team members assessed the pharmacy for compliance with GDPR during each clinical governance audit. Pharmacy team members had individual login

credentials to access the electronic medication records system. And, the computer terminals automatically logged out after a few minutes of inactivity.

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 pharmacy had contact details available for the local safeguarding service. And, a procedure in place to instruct staff about how to deal with a safeguarding concern. Pharmacy team members completed mandatory training every year. Registered pharmacists were required to complete distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years. The pharmacist had last completed training in 2018.

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. The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. 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 learning 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 who was also the store manager, and two dispensers. 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 often related to seasonal health conditions, such as flu, coughs and colds and children's health. They also received and completed The Tutor training modules received on paper each month. These modules covered health related topics. The most recent examples of topics were back to school health, head lice, eye health and vitamins. 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. One example of an objective set was for a team member to spend more time developing their dispensing skills by spending more time working in each area of the pharmacy. One example was preparing multi-compartmental compliance packs. They explained they were being supported by the manager and colleagues to be able to spend more time in their chosen areas. And, they felt their skills were improving.

A dispenser explained that 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, pharmacy team members knew how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, if someone telephoned the pharmacy to ask about multi-compartmental compliance packs, pharmacy team members immediately referred the call to the person working in the pack preparation area to deal with the query. They discussed this was causing frequent distractions to the dispenser preparing packs. And, queries were often of the kind that could be dealt with by other team members. The team had discussed these difficulties. And, they changed their process so that the person who answered the phone tried to resolve the query first, before transferring the call. Pharmacy team members said this had reduced the number of distractions while preparing packs. But, they weren't sure if the new process had reduced the number of mistakes being made.

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 flu vaccinations provided.

Pharmacy team members were rated for compliance with targets using a score card. They discussed progress amongst the team and with the area manager, who supported them to reach their goals. 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 dispensing area on the first floor. And, pharmacy team members used the area 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. And, pharmacy team members kept the room locked when not in use. The pharmacy had a clean, well maintained sink in the dispensary used for medicines preparation. It had a toilet, 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's services are easily accessible to people. The pharmacy has systems in place to help provide its services safely and effectively. It supplies medicines in devices to help people remember to take them correctly. And, it manages this service well. The pharmacy team members identify people taking high-risk medicines. And they mostly provide them with advice to help them take their medicines safely. They store, source and manage their medicines safely.

Inspector's evidence

The pharmacy had ramped 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 to help someone with a hearing impairment. They could produce large-print labels and instructions sheets to help people with a 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. Pharmacy team members used various alert cards that were added to a prescription basket during the dispensing process. For example, one card alerted staff to the presence of a controlled drug on the prescription, others to there being warfarin 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 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 prescriptions for valproate if appropriate. And, they said they would check if the person was aware of the risks if they became pregnant while taking the medicine and give them appropriate advice and counselling. But, they said they would usually not provide the counselling every time the medicine was dispensed to them. This was discussed. And, she gave an assurance that she would provide advice every time. The pharmacy had a supply of printed information material to give to people to help them understand the risks. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. 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 sheet. And, in a communications record book. A dispenser explained that they received most information about changes to packs from the GP in writing. And, if they received information about a change

verbally, they would confirm the changes with the prescriber before implementing them.

The pharmacy delivered medicines to people using a hub driver based at another store. Pharmacy team members populated the delivery records and uploaded them to the driver's electronic device. They also printed each run sheet, which was 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.

The pharmacy obtained medicines from three licensed wholesalers. 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. And, the pharmacy had the right equipment and software in place. Pharmacy team members said they were expecting a phased rollout of the system soon. The pharmacy stored medicines tidily on shelves. And, it kept all stock in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). During the inspection, a pharmacy team member was seen accepting returned medicines from someone. They followed a safe procedure to identify what the person was returning, to make sure the items could be properly segregated. And, they used protective equipment to protect themselves from harm. They disposed of the medicines immediately in to the proper containers. Pharmacy team members kept the CD cabinet 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, these 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. 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. 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.

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 had a set of clean, well maintained measures available for medicines preparation. It had a separate set of measures to dispense methadone. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge that was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment. And, they stored all items 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.