

Registered pharmacy inspection report

Pharmacy Name: Boots, 48 Ashbourne Road, Ingrow, KEIGHLEY,
West Yorkshire, BD21 1LA

Pharmacy reference: 1039645

Type of pharmacy: Community

Date of inspection: 22/10/2019

Pharmacy context

The pharmacy is next door to a health centre in the suburbs of Keighley. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). And, they provide seasonal flu vaccinations. Pharmacy team members supply medicines to people in and multi-compartmental compliance packs. And, they deliver medicines to people's homes. The pharmacy provides a substance misuse service.

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	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 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 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.

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. They further defined their tasks by using a daily task sheet. The sheet listed several tasks that needed to be completed each day. And, defined an approximate time when each task needed to be completed. Tasks included processing prescriptions with items owed to people and printing electronic prescription tokens. And, transmitting the stock order and sending text messages to people to let them know their prescriptions were ready to collect. When each task was completed, pharmacy team members signed the sheet. And, this helped team members monitor their progress through the daily tasks.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members often recorded their own mistakes. And, sometimes the pharmacist made the record. Pharmacy team members discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing had caused the mistakes. And, their most common change after a mistake was to double check next time. Or, to look at where the item was kept seeing if the location could be highlighted to prevent a future mistake. The pharmacist analysed the data collected about mistakes every month. The analysis focussed on quantitative information, such as the number of near miss errors. Or, the frequency of different types of errors. One example in the last review was the frequency of quantity errors. But, there was no information about why this type of error was happening. And, the proposed changes recorded were to reduce the number of quantity errors. Pharmacy team members explained that in response to the highlighted pattern, if they were providing a quantity that was different to the original pack, they double checked the quantity they had dispensed. And, they wrote the quantity on the box and circled the number to indicate the quantity had been double checked before handing it to the pharmacist. 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 made changes to prevent them happening again. For example, highlighting the quantity of medicines dispensed after they had a recent dispensing error involving the wrong quantity being provided. But, during the inspection, the pharmacy manager was not available to provide access to the PIERS system. So, the inspector could not assess the quality of the pharmacy's dispensing error reporting.

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. 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 and controlled drug (CD) security. And they checked 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 people to pick up from the retail area which clearly explained the company’s complaints procedure. It collected feedback from people by using questionnaires. And, people submitted their feedback online. But, pharmacy team members could not give any examples of any changes they had made after receiving feedback from people.

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. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. It maintained a responsible pharmacist record on paper, which 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 and emergency supply records electronically. 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 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. The relief pharmacist explained that he also had his own individual login. And, his login allowed him to access the electronic system, regardless of which branch he was working in. He said this prevented him from having to ask pharmacy team members to log in on his behalf.

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. Pharmacy team members completed mandatory training. 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 2017.

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 relief pharmacist 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. Their knowledge of recently updated procedures was also tested by an SOP quiz every quarter. And, pharmacy team members explained they were given 30 minutes of protected training time per week if possible. 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 one of their objectives. She had identified that she needed to ask more people if they would like to nominate the pharmacy to receive their prescriptions. And, she said this had been a personal objective rather than a pharmacy target because she felt she needed to develop her confidence in asking people the right questions. And, her confidence to be able to explain the benefits of the service to people clearly. She said she was being supported by training from colleagues. And, she was being given time to spend at the pharmacy counter to practice her skills and increase her confidence.

A dispenser explained that 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, pharmacy team members knew how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. They felt able to make suggestions to improve services. And, they explained a change they had made after they had identified areas for improvement. To help prevent medicines being handed to the wrong person, they had changed the way they asked people for their information when they collected their prescriptions. They now asked people to confirm their address and postcode. And, they signed the bag label attached to each bag to confirm the person's details were correct.

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, 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. Most 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 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 also had 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, including people using wheelchairs. The pharmacy has systems in place to help provide its services safely and effectively. And, it uses technology to help reduce the risks of selecting the wrong medicine during dispensing. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And, they manage the risks associated with this service appropriately. The pharmacy sources and manages its medicines safely. But pharmacy team members don't always store medicines tidily. Or, in their original containers. This may increase the risks of them making mistakes whilst dispensing.

Inspector's evidence

The pharmacy had level access from the street, through a power assisted door. Pharmacy team members said they would use written communication to help communicate with someone with a hearing impairment. And, they could produce large-print labels to help people with a visual impairment.

Pharmacy team members used a new electronic system to manage the medicines required for dispensing. When they received a prescription, they either scanned its barcode or entered the data on the prescription manually into the system. The system ordered the medicines required for each prescription. And, these were received the following day. When the stock arrived, pharmacy team members married up each prescription with the required stock. To do this, they scanned the barcode on the prescription. Then, they scanned the barcode on each medicine and a dispensing label was generated. If they selected and scanned the wrong medicine, the system would show an alert and halt the dispensing process. And, the dispensing label would be withheld until the correct product had been scanned. Pharmacy team members explained that since the new system had been installed, they had seen a reduction in the number of picking errors for wrong product and wrong strength. And, this could be seen in the near-miss error data from before the system was installed in July 2019 compared to the data collected after.

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. They requested any monitoring information. And, the pharmacist then made a clinical decision before making a record of the information provided. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, they checked if the person was aware of the risks if they became pregnant while taking the medicine, giving them appropriate advice and counselling. 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 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 sheet. 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 on shelves and in drawers. And, it kept all stock in restricted areas of the premises where necessary. But, the pharmacy's shelves were untidy and very full. Pharmacy team members said this was because the pharmacy had received too much stock during the implementation of the new computer system. The inspector found one section of the shelves that contained several look-alike and sound-alike medicines that were all mixed together. The section contained different strengths of metronidazole, mirabegron and metoprolol. Pharmacy team members said they were aware of the issue. And, they had planned to come to work on the coming weekend to reorganise the shelves and reduce the stock by redistributing items to other branches where possible. Some shelves also contained loose blisters of medicines that had become separated from their original packaging. This was discussed, and pharmacy team members gave an assurance that these would be removed. The pharmacy 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.

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. The 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.