General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1220A Great Horton Road, BRADFORD, West Yorkshire, BD7 4PL

Pharmacy reference: 1088411

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

The pharmacy is in a health centre in the suburbs of Bradford. 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) and the NHS New Medicines Service (NMS). Pharmacy team members provide medicines in multi-compartmental compliance packs. And, they offer a substance misuse service, including supervised consumption.

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 generally 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 openly discuss and record mistakes that happen. But sometimes the person making the mistake is not told. So, they may miss out on learning opportunities. The pharmacy team members make some changes after mistakes happen to reduce the risk of a similar mistake. But they don't always review the records and so may not always make the most effective changes.

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. The pharmacy also had some new SOPs to accompany the installation of a new electronic medication records system. Pharmacy team members had read and signed these procedures. And, the pharmacy superintendent's office had scheduled the procedures to be reviewed in twelve month's time, rather than the usual two years. 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 latest audit had identified that pharmacy team members had not carried out a weekly check of the controlled drug (CD) register running balances. A task was assigned to the pharmacy manager to complete the checks. And these were completed the following day.

The pharmacist and accuracy checking technician (ACT) highlighted near miss errors made by pharmacy team members when dispensing. Pharmacy team members said they were told by the pharmacist when they had made a mistake. And, they were asked to identify the mistake themselves before fixing the problem. But, they said the ACT did not always point out near miss errors to them, choosing instead to fix the issues herself. This meant they did not always get the opportunity to learn from their mistakes. Pharmacy team members recorded their own mistakes. They discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time. The pharmacy team member appointed patient safety champion analysed the data collected about mistakes every month. But, they did not analyse the data for patterns of cause. And, in the samples seen from the last nine months, the actions proposed to help prevent errors was the same or similar. And, the action was usually to follow the procedure for identifying look-alike and sound-alike medicines. This meant pharmacy team members were not reflecting on their actions each month to establish whether they had achieved their desired outcomes to reduce certain errors. But, pharmacy team members explained that in response to common error with wrong quantities of medicines, they had incorporated an extra step in to the dispensing process. This included

them counting the quantity dispensed and writing the quantity on the box. Pharmacy team members explained this had helped to reduce the frequency of quantity errors being made. 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. In several examples of reports seen, pharmacy team members recorded little or no information about why the error had happened or what had been changed to prevent it happening again. And, one recent dispensing error involved LASA medicines, despite there being a system in place to prevent such an error. And, despite LASA medicines being the primary focus for improvement in several previous patient safety reviews.

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 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 were required to write 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. But, pharmacy team members admitted that the process was not always followed. And, they did not always write the name of the LASA medicines on the PIF. They also said they were not always told if they had forgotten to write on the PIF because the person checking the prescriptions did it for them.

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. Pharmacy team members gave an example of feedback given to stores across the area where people felt pharmacy staff were not very friendly. Pharmacy team members explained that although the feedback had not been given to them directly, they had discussed the feedback and the way they approach people in the pharmacy to make them feel welcome. And, they identified people who preferred to speak to specific pharmacy team members and always tried to accommodate their needs where possible.

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, 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 and emergency supply records electronically. But during the inspection, the computer system was not working. So, records could not be seen. 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 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. The team members feel comfortable discussing their concerns about the pharmacy's ways of working. And they work well together to resolve these issues. They undertake training regularly. And, they reflect on their own performance, discussing any training needs with the pharmacist and other team members. They support each other to reach their goals.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a pharmacy technician and two dispensers. There was also an additional relief pharmacist to help whilst the pharmacy implemented the new electronic patient medication records system. 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. Pharmacy team members took part in an appraisal every six months. They 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. The example was for them to develop their skills to direct the team and delegate more effectively when the manager was absent. They said they were being supported by the manager through teaching, observation and feedback to help achieve the goal. And, they felt they were making good progress.

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 said they were usually told by the pharmacist when they had made a mistake. The discussion that followed did not always fully explore why they had made the mistake. But, they said they would usually try and make changes to prevent the mistake happening again. Sometimes the ACT didn't inform team members of their errors. And made the record for them. So, they missed opportunities to learn.

The team members discussed ways of working together. One team member, who had been responsible for the dispensing of all the multi-compartmental compliance packs felt under pressure doing this, particularly before annual leave. The pharmacy team agreed to change the system. The team organised the packs into three groups, with three team members taking on responsibility for one group each. And, changes to the organisation of the room meant the team could monitor the preparation process more effectively. 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. The pharmacist felt supported to reach their targets by the area manager. The pharmacist regularly discussed how to meet targets with the area manager. Together they developed a plan to support the team to change their ways of working if necessary.

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. The pharmacy kept equipment and stock on shelves throughout the premises. It 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 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. And, the pharmacy had air conditioning. 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 these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they give these people some advice to help them take their medicines safely. But, they don't always provide them with relevant written information.

Inspector's evidence

The pharmacy could be accessed through an automatic door from the surgery car park. It also had a door from the surgery reception area. 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. And, they would offer to order medicines on peoples' behalf if they could not do it themselves.

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 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 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. And, pharmacy team members added the descriptions of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's master record sheet. But, they did not keep a record of the prescriber who had initiated any changes. So, it might be difficult to resolve any future queries.

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 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. But, she did not routinely check if they were on a pregnancy prevention programme (PPP). And, the pharmacy did not have any printed information material to give to people to help them understand the risks. The pharmacist gave an assurance that they would obtain some information materials as soon as possible. And, that they would start to make enquiries about people's enrolment in a PPP and consult current guidance about managing the risks for people taking valproate. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training and new procedures had been implemented to accompany the installation of the new electronic patient medication records system. The system also provided the facilities to scan and check FMD compliant packs. Pharmacy team members said they were still getting to grips with the new system and ironing out implementation issues. But, they hoped to be using the system fully in the coming days. Pharmacy team members were aware that if the system identified a falsified medicine, they would segregate the pack immediately. And, they would seek advice from head office about the best course of action.

Pharmacy team members checked medicine expiry dates every 12 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.

The pharmacy delivered medicines to people 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. 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 they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. 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.