General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit B, Arnison Retail Centre, Pity Me, DURHAM, County Durham, DH1 5GB

Pharmacy reference: 1089098

Type of pharmacy: Community

Date of inspection: 27/08/2019

Pharmacy context

This pharmacy is within a retail park on the outskirts of the town centre. And it is open seven days a week. The pharmacy dispenses NHS and private prescriptions. It offers a range of services including seasonal flu vaccinations, various travel vaccinations and other vaccinations such as chicken pox and meningitis. It provides a substance misuse service, with supervised methadone consumption. And supplies medicines in multi-compartmental compliance packs to help people take their medicines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has processes and written procedures that the team members generally follow. The team members have a clear understanding of their roles and tasks. The pharmacy keeps all the records as required, by law in compliance with standards and procedures. And it provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people. The pharmacy's team members generally record, report and learn from errors and mistakes during the dispensing procedure. But on occasions these are not always recorded, so the team may miss out on opportunities to improve and reduce the risk of a similar error.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions and controlled drugs (CD) management. These were subject to regular review by the superintendent. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The team undertook quizzes on SOPs to ensure their understanding. The team could advise of their roles and what tasks they could do. There were also several other corporate checks undertaken weekly to manage the running of the pharmacy. The team followed a model day planner and advised that this was important, especially with the new computer system. As this ensured the pharmacy undertook tasks at the correct times which assisted with work.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate room for compliance pack preparation. There were workstations at the main counter and a small rear dispensing area. The team tried to keep this area tidy. On one side of the available bench space there were tubs waiting for the team to complete the dispensing process. These prescriptions had been prepared and waiting for the stock and labelling, following the process. The tubs kept the prescriptions and medicines together. There were papers and other items on most of the remaining spaces. This meant the team had limited bench space for working on. This included compliance packs waiting for a check. The team advised they were looking at trying to extend the area along the shelving area for storing tubs and to provide more space. And keep the dispensing areas clearer.

The pharmacy generally recorded near misses found and corrected during the dispensing process. The team recorded these on a specific template. But advised that on occasions at the moment some near misses were being missed in the recording process. And this was an area which the team would work on. Over the last few months there had been absences and combined with some of the services, taking the time of the pharmacist, these were not always recorded. Examples of entries made included paracetamol capsules, with tablets given, venlafaxine with the incorrect quantity, 56 instead of 28, and reboxetine, with 16 required but the wrong amount given. The team completed comments to assist in the learning such as a split box which had contributed to the incorrect quantity. The team undertook monthly patient safety reviews (MPSR), following the company procedure. They had noted an action to tidy the shelves ready for the implementation of the new computer system which would help with this process. And noted that they need to pay more attention to quantities of medicines and different strengths. They carried out briefing reviews to discuss the MPSR and included topics such as

familiarising themselves with the new computer system and any safety alerts. They also discussed the company internal document The Professional Standards which included learning and this month had added pregabalin and gabapentin to the Look Alike Sound Alike drugs (LASA) drug items. The team had the list of the current LASA items at each of the workstations. And the team members noted these on the pharmacist information forms (PIFs), following the company procedure. The team members used PIFs for all prescription to communicate messages throughout the dispensing process. They recorded information such as whether the medicine was new for the patient or if there were any changes since they had last received it. They also recorded interactions, allergies or if the patient was eligible for any service such as a medicine use review (MUR) or flu vaccination.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process and how to provide comments. The pharmacy gathered feedback through the annual patient satisfaction survey. And had looked at improving the waiting areas and waiting times. There was a procedure to record and report dispensing errors and records seen that this procedure was usually followed. But a recent concern which a person had raised with the General Pharmaceutical Council (GPhC) had not been logged following the company process. The store manager explained that this was out of character of the pharmacy's normal practice. She made some inquiries but due to holidays and shift patterns there was no one at the time who could recall any specific detail. This was subsequently investigated within the store and the concern dealt with through the GPhC process. The team discussed any incidents at their briefing meetings. The store manager was keen to investigate the recent concern and ensure the team learnt from this and that she reinforced the importance of recording any incidents. All the team members could record incidents and usually left any items in the manger's box for attention. So, she was aware and could review.

The pharmacy had current indemnity insurance in place. The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacists completed the responsible pharmacist records. The pharmacy kept CD registers as required. The team annotated any errors appropriately. And they followed the correct procedure to record any issues. They used the company process map as a guide, to assist in resolution of any discrepancies. The pharmacy carried out weekly audits on stock. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy kept the records for private prescriptions electronically. And kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information on the confidential data kept and how it complied with legislation. And displayed a notice on how it looked after information. The team had read General Data Protection Regulation (GDPR) information. And completed training on eLearning for this. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. The team stored completed prescriptions safely. And they kept patient sensitive information securely. The pharmacy team stored confidential waste in separate containers for offsite shredding.

The pharmacy had safeguarding information including contact numbers for local safeguarding available for the team. The pharmacist had undertaken level 2 CPPE training. And the team had all completed training on eLearning. And completed Dementia friends training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has adequate staffing to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT) and two dispensers working in the pharmacy. In addition, there were three other dispensers. One of the dispensers was the store manager and worked in the dispensary to cover and another dispenser, was the assistant store manager and worked 15 hours weekly in the dispensary. The pharmacy received cover in the dispensary, and the dispenser present, was a relief covering a dispenser who was currently off. The pharmacy had two regular pharmacists who worked 40 hours each in the pharmacy. The pharmacy had had a few changes in staff recently and absences which had meant there had been challenges. The team discussed the challenges with managing the workload due to the vaccination services which removed the pharmacist from the dispensary for periods of time. There was no overlap of pharmacists which the pharmacy had previously had for two days a week. Also managing the counter took time away from dispensing tasks and interrupted dispensing, as there was no longer a staff member who worked as counter assistant only. Due to the staffing the ACT did not use her qualification as often as before, as she was involved in dispensing. The pharmacist working was a company relief and there was also a dispenser present who was the role implementation manager on the new computer system. There were some regional members having a meeting in the building and near the end of the day one of the pharmacists came to assist as the pharmacy was busy and the computer system had gone down for a while. The team found the ‘offline dispensing pack’ and hand wrote labels for people who required medicines straight away such as cephalexin. The pack included statutory warning labels to be put on the dispensing boxes to ensure people had the required information. The team explained to people the system had gone down and most people were happy to come back as they did not require their medicines immediately. Not all the team knew of the location of the offline pack.

Certificates and qualifications were available for the team. 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. They also received and completed The Tutor training modules received on paper each month. These modules covered health related topics, such as new products and seasonal health conditions. The company tested pharmacy team member’s knowledge of The Tutor modules every quarter via an online quiz. The pharmacy had a yearly appraisal process. Pharmacy team members discussed their performance with the manager. They then set objectives to address their needs and they discussed any personal learning objectives. The role implementation manager advised that she attended the pharmacies prior to the implementation of the new computer system, Columbus, twice. Then she came during the installation and start of the process. And followed up with two further visits. She was available to assist at any time and was contactable for support. The team had undertaken training online and had laminates to help with the processes during the roll-out

phase.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacists or the store managers. There was a whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are of a suitable size for the services it provides. And people can have private conversations with the team in a consultation room.

Inspector's evidence

The pharmacy was clean and reasonably tidy. And fitted out to an acceptable standard with limited dispensary space. The rear part of the dispensary was minimal with workstations at the counter also used. The team had reviewed the layout due to the new ways of working, with the new computer system. The rear dispensary had limited bench space to work in due to tubs piled ready for labelling, taking up one side of the small available dispensing bench space. When the pharmacy received deliveries, the totes boxes restricted the access to the sink area which was in a corner. The team members tried to keep the floor spaces clear and attended to deliveries to place items on the shelves as soon as practicable to remove boxes.

The sink in the dispensary for preparation of medicines was clean but had a very unpleasant odour each time the team used the tap for water. The team advised that they had reported this on occasions and that they had been told due to the type of system the smell could not be resolved. They discussed ways to mask the smell for the future if there could be no otter resolution. Separate hand washing facilities were in place for the team. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had an adequately sized, signposted, sound proofed consultation room which the team promoted for use. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy team kept the consultation room locked when not in use. There were curtains which the team pulled across the window when required for more privacy. The counter was clearly observed from the dispensary and the team were aware of customers requiring attention.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it provides its services safely and effectively. The pharmacy team takes steps to identify people taking some high-risk medicines. And they provide people with advice. They dispense medicines into devices to help people remember to take them correctly. The pharmacy stores and manages its medicines safely. And it delivers medicines to peoples' homes. The pharmacy gets it medicines from reputable suppliers. It takes the right action if it receives any alerts that a medicine is no longer safe to use.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a touch pad at the entrance for easy access. There was some customer seating. And a working hearing loop in place. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. And reflected the change in hours. But the pharmacy had two version of practice leaflets on a carousel and neither of them had the correct hours of opening. The pharmacy had a range information leaflets on a variety of healthcare topics. The store was a large store with a range of health and beauty products. Within the store the pharmacy area was clearly defined. People could not access Pharmacy only medicines and the team assisted them when requiring these items. And provided advice as required.

The pharmacy received referrals from NHS 111 through the NHS Urgent Medicines Supply Advanced Service (NUMSAS). The patient had contacted NHS 111 for advice and NHS 111 determined they required urgent access to a medicine or appliance that they had been previously prescribed on an NHS prescription. The pharmacy then processed the request to ensure the suitability and appropriateness for the patient. Most referrals led to the pharmacy making a supply. And on some occasions the pharmacy directed the patient to another healthcare service such as their general practitioner. The pharmacy received referrals through the Digital Minor Illness Referral service (DMIRS). The digital minor illness referral service (DMIRS) referred patients from NHS 111 or NHS 111 online, straight to their nearby pharmacist, rather than to services like doctors or hospitals. On most occasions the pharmacy could assist the patient, and, on some occasions, it referred people to other providers for further assistance.

The pharmacy undertook Medicine Use Reviews (MUR) and the New Medicines service (NMS). It also provided a seasonal flu vaccination service. It undertook several other vaccinations such as chickenpox, pneumonia, meningitis and mumps, measles and rubella (MMR). They usually referred people to their doctor for the MMR as this was available through the NHS service. They offered a range of travel vaccinations such as yellow fever, rabies, cholera, hepatitis A and B and typhoid. The team booked the appropriate time slots for the vaccinations. There was usually one pharmacist only, so the time slots were booked to allow time in-between for checking any prescriptions. They normally only booked four slots a day as some initial ones for travel vaccines required 30 to 40 minutes. There was an accuracy checking technician (ACT) but as she was often involved in dispensing so could not complete the accuracy check. On occasions the pharmacist undertook some clinical checks prior to being away from the dispensary, so the ACT could check. The team advised they usually received some days of full time ACT cover during the main flu season. The team signposted to other healthcare services such as needle exchange.

The pharmacy supplied medicines to around 25 people in multi-compartmental compliance packs to them take their medicines. The team made these up four weeks at a time. And used a tracker to monitor the progress to assist in ensuring they completed the packs in plenty of time for supply. The team had patient Medisure profile sheets for each patient. And documented any changes which provided an audit trail. The packs had descriptions of the medication and the team provided patient information leaflets (PILs) with the first pack of each cycle. The team prepared these in a room at the rear of the pharmacy building and brought them in to the main dispensary for a check. The pharmacy offered a substance misuse service for methadone. The team labelled the bottles with the dates of the instalments. The pharmacy kept all a person's bottles together in a clear bag in the CD cabinet. The pharmacist checked date of birth or postcode at hand out. And the pharmacist asked what quantity people were expecting. The pharmacist confirmed when people had taken their last dose, if they had missed a collection.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked, at found compliance with this process. The team used a quadrant stamp on the prescription to show that the pharmacist had completed a clinical check. It also showed who had labelled, dispensed, accuracy checked and who handed out the items. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so the contents could be checked again, at the point of hand-out. The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The CD stickers had a space to record the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. The team usually completed these.

There was a selection of laminated cards which the team used to add to the tubs during the dispensing process to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling. They also completed the pharmacist information forms (PIFs) with any required information such as to text once completed or if an MUR was suitable. The pharmacy had a 'perfect PIF' displayed on a notice board to remind the team of relevant points to include. When the pharmacy could not provide the product or quantity prescribed, full patients received an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable at the current time for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. And counselled people as required. They advised that an alert came up at the time of dispensing, so they added this to the PIF as a reminder. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs.

The pharmacy obtained medicines from reputable sources. And used recognised wholesalers. The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had two refrigerators from a recognised supplier. They were appropriate for the volume of medicines requiring storage at such temperatures. The pharmacy kept one in the store at the back and the pharmacy team kept it locked to avoid any unauthorised access. They used this to store most of the vaccines. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy was aware of the Falsified Medicines Directive (FMD)and that the changes in the computer system were a start for the process. They had received training on the computer system and expected more training prior to the FMD being live in the pharmacy. They did not know when this would occur. The pharmacy had received training material on the new computer. And they had received training in-house prior to the change. And follow-up in-house sessions to support the team with the new system. The pharmacy team downloaded the prescriptions and data entered on the system which linked with the patient medication records and produced information such as interactions. This stage did not produce the labels. It ordered the stock from this information and when the stock came in, the team scanned this and put it on shelves alphabetically. The team then picked the stock for the prescriptions, scanning the packs. They did not scan out yet.

The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. And included these on the monthly patient safety review as a reminder to the team.

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 to protect people's confidentially.

Inspector's evidence

The pharmacy team members had access to a range of up to date reference sources, including the British National Formulary (BNF). They used the resources on the Boots system as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves and alcohol hand washing gel. The pharmacist washed their hands in the dispensary and then used the hand washing gel prior to carrying out services such as vaccinations. The pharmacists washed and gelled their hands several times during administration of services. The team mentioned that it would be beneficial to have a sink in the consultation room due to the volume of vaccinations administered.

The pharmacy stored medication waiting collection on shelves and people at the counter could not see any confidential information. The team filed these in boxes in a retrieval system out of view, keeping details private.

The computer in the consultation room was screen locked when not in use. The computer screens were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations.

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.