General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Kensington Street Health Centre, Whitefield Place, Girlington, BRADFORD, West Yorkshire, BD8 9LB

Pharmacy reference: 1089898

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

The pharmacy is adjacent to 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. They offer a substance misuse service, including supervised consumption. And, they provide flu vaccinations during the winter season.

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. The pharmacy asks people using the pharmacy for their views. It 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 record and discuss mistakes that happen when dispensing. But, they don't always use the information collected about mistakes to inform the changes they make. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the pharmacy superintendent reviewed them regularly. The sample checked were last reviewed in 2017 and 2018. And the next review was scheduled for 2019 and 2020. Pharmacy team members had signed to confirm they had understood the SOPs since they were last reviewed. 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. There were no findings for improvement in the recent examples seen. The pharmacy had a pharmacy technician who was accredited to perform a final accuracy check of prescriptions (ACT). The technician explained that they were able to check anything that had been clinically checked by the pharmacist first. The pharmacist confirmed they had performed a clinical check by signing on the prescription in a quadrant stamp. The technician and the pharmacist completed a declaration every year to reaccredit the technician's checking competence. And, the technician was subject to mandatory revalidation as part of their professional registration.

The pharmacist and ACT 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 discussed why the error happened. But, they rarely recorded any detailed information 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. But, pharmacy team members had separated look alike and sound alike (LASA) medicines involved in mistakes to prevent a future recurrence. The pharmacy technician analysed the data collected about mistakes every month. The examples of the analysis seen focussed on the quantity of errors being made. And, the quantity of different types of mistakes occurring, such as wrong strength or wrong form errors. They did not analyse the data for patterns of cause. But, pharmacy team members said they discussed why each mistake happened at the time, despite not capturing the information in the records. The ACT said in the two months since they had been working at the pharmacy, they had noticed the same patterns occurring in the error data. And, she intended to address this by exploring causes with the team further and encouraging them to record more information. 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. But, pharmacy team members could not access the system during the inspection because the pharmacy manager was absent. And previously submitted records required the manager level of access to be able to view them. So, the inspector could not assess the quality of reporting at this inspection. A pharmacy team member gave an example of a recent error,

which they felt had been caused by them being distracted by people at the pharmacy counter. They had felt under pressure to work faster and felt they had not been able to thoroughly check their work. The team member said they had discussed the incident with the team. And, they said they were now mindful to always double check their work before passing it to someone to check, regardless of the situation. But they had not explored the causes or any other solutions further to try and prevent the mistake happening again.

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.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise the company complaints procedure to people in the retail area. It collected feedback from people by using questionnaires. 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. 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, pharmacy team members could not find the retained private prescriptions to match the records. So, the accuracy of the records could not be assessed at this inspection. 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. And, the locum pharmacist said they would use the internet to find out local contact information if they were working somewhere unfamiliar. 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 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 locum, a pre-registration pharmacist, a pharmacy technician, 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. 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 vitamin. 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. The pharmacy had a yearly appraisal process. Pharmacy team members discussed their performance with the manager and were given the opportunity to identify any learning needs. They then set objectives to address their needs. A team member gave an example of a one of their objectives. They had identified that their knowledge of over-the-counter medicines and advice could be improved, after having spent a long time in other areas of the pharmacy. The said they were being supported by training from colleagues and were being given time to spend at the counter to practice their skills and increase their confidence.

A pharmacy team member explained they would raise professional concerns with the pharmacist or area manager. They felt comfortable raising a concern. And confident that their 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 explained how the pharmacist told them when they had made a mistake. They discussed the mistake and the likely causes, even though this information was not always recorded. And, they tried to make changes where possible to prevent the mistake happening again.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They had identified that people dispensing were often being broken off from their tasks to help people at the pharmacy counter. And, this was sometimes causing mistakes. So, they had discussed the issue and were all being mindful to try and protect people while they were dispensing, particularly when they were preparing multi-compartmental compliance packs. But, they had also agreed that if someone was at a safe stage to be able to break off, they would do so to help relieve the pressure on the rest of the team.

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

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

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And, the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy 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 people who don't speak English. 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 provide these people with some advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street, through a power assisted door. It 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, several team members could also speak other languages spoken locally besides English, such as Urdu and Punjabi.

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(s) 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. 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, using a document called a Medisure progress log.

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 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, the pharmacy did not have any printed information material to give to people to help them understand the risks. The pharmacy technician gave an assurance that they would obtain some information materials as soon as possible. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They were aware that they were going to receive training on the subject but did not know when this would be. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. But the pharmacy didn't have the right scanners, software or SOPs relating to FMD and so was not legally complaint. Pharmacy team members said they were waiting for a new computer system to be installed later this year. A pharmacy team member gave a clear explanation of the protocols in place to make sure over-the-counter medicines were provided to people safely. They gave examples of restricting the quantity of co-codamol and pseudoephedrine they would supply. And they gave examples of requests for certain products they would immediately refer to the pharmacist. Pharmacy team members were also heard giving sound counselling advice to people about how to take their medicines, including giving advice about how to take a course of antibiotics effectively.

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. The pharmacy responded to drug alerts and recalls. And, pharmacy team members quarantined any affected stock found for destruction or return to the wholesaler. And, they recorded any action taken. 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. 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. Pharmacy team members explained they sent people a text message to tell them a delivery was waiting to be sent to them. People then rang the pharmacy to inform the team of when they would be in. And, pharmacy team members arranged deliveries for their preferred time. Or, people called in to the pharmacy to collect their prescriptions. Team members explained this had helped to significantly reduce the number of failed deliveries due to people not being at home.

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 these 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.