General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 1, Kingston Park Shopping Centre, Brunton Lane, NEWCASTLE UPON TYNE, Tyne and Wear, NE3 2FP

Pharmacy reference: 1090272

Type of pharmacy: Community

Date of inspection: 18/03/2024

Pharmacy context

This is a busy pharmacy in a retail park in Newcastle. Its main activities are dispensing NHS prescriptions, and it provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a range of NHS services and provides a delivery service, taking medicines to people in their homes.

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’s written procedures help team members provide services safely and effectively. Team members record mistakes they make during the dispensing process, and they make changes to help prevent a similar error happening again. They mostly keep the records required by law and they keep people’s private information secure. They know how to respond appropriately to concerns about the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These were reviewed by the company's superintendent (SI) pharmacist team every two years. Team members accessed them on an electronic platform where they were directed to read newly updated SOPs when they were released. And they completed quizzes to confirm their understanding of them.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who made the mistake recorded the details about it. And if the person who made the mistake was not present, the pharmacist made the record. The pharmacist had informal conversations with team members about near misses. A monthly patient safety review was completed to identify any trends in near misses. This had identified that quantity errors were the most common mistake made. As a result, the pharmacist had directed team members to ask another team member to double check the quantities dispensed before completion of the final accuracy check. Team members had also separated certain higher-risk medicines such as quetiapine from other medication in the dispensary to reduce the risk of selection mistakes. The pharmacy completed incident reports for mistakes that were identified after a person had received their medicine, known as dispensing errors. These were recorded electronically and shared with the manager. The pharmacy had a complaints procedure which was detailed in the pharmacy's practice leaflet. Team members aimed to resolve any complaints or concerns informally. If they were not able to resolve the complaint, they escalated it to the manager who worked in the pharmacy.

The pharmacy had current professional indemnity insurance. Team members knew which tasks they were responsible for by following a daily task list. They were observed working within the scope of their roles. They knew which tasks could and could not take place in the absence of the pharmacist and knew the procedure to follow if the RP had not arrived for the start of their shift. The accuracy checking pharmacy technician (ACPT) was comfortable to check prescriptions for all medicines, and this had been agreed with the regular pharmacist. The ACPT sometimes completed the final accuracy check before prescriptions had been clinically checked by the pharmacist. The medicines were put aside until the pharmacist had completed the clinical check. Team members were aware that they were not to move any medicines into the collection area until all checks were complete. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP. The RP record was complete. The pharmacy had a paper-based register for recording the receipt and supply of its controlled drugs (CDs). The entries checked were in order with a few minor omissions of the address of the supplying wholesaler. Team members checked the physical stock levels of medicines matched the running balance in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them. And the destruction was witnessed. The pharmacy kept

certificates of conformity for unlicensed medicines. The pharmacy kept complete electronic records for its supply of medicines made against private prescriptions and kept associated paper prescriptions.

The pharmacy had a data processing notice displayed in the retail area informing people of how their private data was used. Team members received annual training regarding information governance and the General Data Protection Regulation. The pharmacy kept confidential waste separately for collection and destruction by the company's wholesaler. Team members received annual training about safeguarding, and they referred any concerns about vulnerable people to the pharmacist. The pharmacists had completed their level three safeguarding training and the trainee pharmacist had completed levels one and two. The pharmacy displayed a chaperone policy on the door of its consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team with the appropriate training and skills to manage the workload. The pharmacist effectively supervises team members who are not yet qualified in their role and helps them learn. Team members receive regular ongoing training to develop their skills and knowledge. And they ask appropriate questions when helping people with their healthcare needs.

Inspector's evidence

The pharmacy employed two full-time pharmacists and a part-time pharmacist who covered the pharmacy's opening hours. At the time of the inspection, one of the full-time pharmacists, who was the RP, a locum pharmacist, a trainee pharmacist, three dispensers and a medicines counter assistant (MCA) were on duty. Other team members, not working, included an ACPT, a trainee pharmacy technician, five dispensers, one of whom was the manager and a MCA. Two assistant managers who primarily worked in the retail area of the store were available to assist when required. One of the assistant managers had recently completed a dispenser's training course and the other had completed a MCA qualification training course. Team members had completed an accredited training qualification course for their roles or were in the process of completing one. The trainee pharmacist, trainee pharmacy technician and a trainee dispenser's training were overseen by one of the regular pharmacists who acted as their supervisor. And they received protected learning time in order to complete their training in a timely manner. All team members completed training modules using an online platform during quieter periods in the working day. They were directed to complete training by the manager. Team members received a monthly newsletter from the SI's office which included learnings about errors from other pharmacies in the company so team members could implement changes if needed. Both pharmacists working had completed training to deliver the NHS Pharmacy First service, which had included face-to-face training in the use of an otoscope and throat examination. The trainee pharmacist had completed training to administer influenza vaccinations.

Team members were observed working well together to manage the workload. And they supported each other with queries. Annual leave was planned in advance and part-time team members could increase their hours to help support periods of absence. Pharmacist holidays were covered by either relief pharmacists or locums. The pharmacy manager planned rotas in advance to ensure there was enough team members working. Team members received six monthly performance reviews. There was an open and honest culture amongst the team, and they felt comfortable to raise concerns and knew who to raise them with if required. The pharmacy set its team members targets but they did not feel under pressure to achieve them.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse, for example, medicines containing codeine. They referred such requests to the pharmacist or gave advice for people to contact their GP. The pharmacists had supportive conversations with people and referred them to their GP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has suitable facilities for people requiring privacy when accessing the pharmacy’s services.

Inspector's evidence

The pharmacy was within a larger retail store. It had a medicines counter which was well organised and portrayed a professional appearance. Unauthorised access to the dispensary was managed by a barrier between the medicines counter and dispensary. The dispensary was clean and tidy and had designated spaces for the completion of tasks and storage of medicines. Team members worked behind partitions which allowed them to complete their tasks without distraction. The pharmacist's checking bench allowed for effective supervision of the dispensary and medicines counter. The dispensary had a sink which provided hot and cold water for handwashing and professional use. Toilet facilities were clean and had separate handwashing facilities. Team members used an upstairs room for the preparation of multi-compartment compliance packs. The room was also used as an office and was kept locked when not in use. The pharmacy was cleaned daily by a cleaner. The temperature was comfortable throughout and the lighting was bright.

The pharmacy had a small lockable consultation room where people could have private conversations with team members and access services from the pharmacist. The room had a sink with hot and cold water, two chairs and a desk and computer.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members supply people with the necessary information to help them take their medicines correctly. They manage and store medicines as they should. And they complete checks on them to ensure they remain fit for supply.

Inspector's evidence

The pharmacy had automatic doors and level access from the pavement which helped people using wheelchairs and with prams enter the premises. It had a range of healthcare leaflets for people to read. Team members provided large print labels if needed to help people read about how to take their medicines. And there was a hearing loop used for those with hearing aids. The pharmacy provided the NHS Pharmacy First service which was underpinned by patient group directions (PGDs) and these were available in paper form for easy referencing.

Team members used baskets to keep people's prescriptions and medicine together and to prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Laminated cards were attached to prescriptions highlighting a fridge line, CD, or higher-risk medicine such as valproate. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. They were aware of the requirement for issuing valproate in original manufacturer's packs. Pharmacists confirmed they counselled people taking higher-risk medicines, including valproate. Team members were observed completing suitable checks when handling out medicines to people to ensure they were supplied to the correct person. They provided people with owing slips if they could not provide them the full quantity of prescribed medication. If the team were unable to supply the medicine, they either referred the person back to their GP or liaised directly with the GP for an alternative.

The pharmacy had a delivery service, taking medicines to people in their homes. Team members produced a list of the deliveries for the driver and the inclusion of a fridge line or CD was highlighted. Any failed deliveries were returned to the pharmacy for the person to collect or have delivery rearranged.

The pharmacy supervised the administration of medicine for some people. Team members managed the service by preparing the medicine on a weekly basis, so the medicine was ready for people to collect. The pharmacy provided a small number of people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. Team members ordered the prescriptions two weeks in advance so there was time to resolve any queries with the person's GP. Each person had a medication record sheet which documented the medicines taken and the dosage times. Team members received communications about changes to people's medicines from the GP surgery and these were kept with the person's medication record sheet to maintain an audit trail. Descriptions of the medicines were provided on the packs so they could be easily identified. And people received patient information leaflets (PILs) monthly, so they had information about their medicines.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were

stored behind the medicines counter which helped ensure sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines which involved checking different areas of the dispensary at different times. The last recorded check was in February 2024. Any medicines that were going out of date in three months were highlighted for use first. Medicines with a shortened expiry date on opening were marked with the date of opening, and sometimes with the date it would expire. But a medicine past its shortened expiry date was removed for destruction during the inspection. Team members confirmed they checked the expiry dates of medicines during the dispensing and final accuracy checking processes. The pharmacy had two fridges to store medicines that required cold storage. Team members generally recorded the temperatures daily, and these showed the fridge was operating between the required two and eight degrees Celsius. There had been three omissions of recorded temperatures in the past three months. Team members received notifications about drug safety alerts and recalls directly from the company on an online platform. The alerts were printed, actioned and filed. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF) and Medicines Complete. It had a blood pressure monitor and ambulatory blood pressure monitor for use in the NHS hypertension case finding service. The ambulatory blood pressure monitor was marked to show when it had been calibrated and when it was next due. The pharmacist explained it was cleaned after each use with disinfectant wipes. The pharmacy had equipment including otoscopes, tongue depressors and a thermometer used in the NHS Pharmacy First service. And it had crown or BS marked measuring cylinders which were marked to identify which were for water and which were for liquid medicines. And it had triangles used for counting tablets.

The pharmacy had the use of a cordless telephone and a partition at the dispensing bench that helped with the privacy of telephone conversations. It stored medicines awaiting collection in a way that prevented unauthorised access to people's private information. Confidential information was secured on computers using passwords. And screens were positioned in the dispensary and consultation room in a way that prevented unauthorised people from seeing confidential information.

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.