

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, South Hetton Medical Centre, Front Street,  
South Hetton, DURHAM, County Durham, DH6 2TH

**Pharmacy reference:** 1092368

**Type of pharmacy:** Community

**Date of inspection:** 02/09/2019

## Pharmacy context

This pharmacy is within a medical centre. It dispenses NHS and private prescriptions. And offers advice on the management of minor illnesses and long-term conditions. It offers a range of services including supervised methadone consumption and flu vaccinations. It supplies medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medicines to people's homes.

## 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   |
|--|-------------------|------------------------------|------------------|---|
| <b>1. Governance</b>                               | Standards met     | 1.2                          | Good practice    | The pharmacy team members consistently record and learn from the mistakes they make whilst dispensing. And they make changes to their ways of working to further reduce the risk of repetition. |
| <b>2. Staff</b>                                    | Standards met     | N/A                          | N/A              | N/A   |
| <b>3. Premises</b>                                 | Standards met     | N/A                          | N/A              | N/A   |
| <b>4. Services, including medicines management</b> | Standards met     | N/A                          | N/A              | N/A   |
| <b>5. Equipment and facilities</b>                 | Standards met     | N/A                          | N/A              | N/A   |

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has suitable up-to-date procedures to help identify and manage the risks to its services. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. And consistently record and learn from these. The pharmacy keeps all the records as required by law, in compliance with standards and procedures. 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.

### Inspector's evidence

The pharmacy had up-to-date 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 of prescriptions, high-risk medicines and controlled drugs (CD) management. The company reviewed these and every quarter sent out some for the team to read. The team completed quizzes at the end to test their understanding. The pharmacist highlighted any changes to alert the team to these. 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 had a laminated copy of the 'Model day' which they used to ensure they complete tasks at the right time. The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate room for compliance pack preparation. The team used a computer terminal at the front for walk-in prescriptions and passed any to the rear dispensary if they had larger items or required more privacy. They dispensed the prescriptions for the collection service at the rear bench. The pharmacy team members used tubs throughout the process to keep prescriptions and medicines together. They had red tape round the top of some tubs. This indicated these were for people who were waiting in the pharmacy.

The pharmacy recorded near misses found and corrected during the dispensing process. The team recorded these on a specific template. Each member of the team had their own log. Examples of near misses included, ramipril with tablets on the prescription and capsules given, saline nebulas with salbutamol given and the wrong quantity of 30 given when the prescription required 28. The team completed any reasons such as 'patient gets both'. The team were good at recording the detail which assisted in learning. They noted actions to try to avoid distractions from walk-ins, particularly when they were busy. They shared their own near misses with the rest of the team for learning. This was generally done as they had occurred. The pharmacy had a team briefing weekly on any near misses. They used shelf alerts to alert the team to take care at the picking stage. And had all the look alike sound alike (LASA) drugs marked with shelf alerts. They read the internal magazine, The Professional Standard, and shared learning from it. The patient safety champion had conference calls with other pharmacies in the region. And they shared ways to learn and improve. They completed a Monthly Patient Safety report and all discussed this, read and signed it.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the

complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey. There was a procedure to record and report dispensing errors. The team followed the company's SOP for complaints. All the team could record any incident. And they recorded any incidents which were then included and discussed on the Monthly Patient Safety report. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. The pharmacy completed the CD registers as required with headings filled in, running balances maintained and the register indicated weekly stock audits were undertaken. Physical stock of an item selected at random agreed with the recorded balance. The pharmacist made the appropriate adjustments in the methadone balance, within the acceptable tolerances set by the company. 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 records for private prescriptions electronically. There were few emergency supply (ES) entries as they referred most people to the surgery for a prescription. The pharmacy 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. It had a Data Protection Notice displayed. on how it looked after information. The team had read General Data Protection Regulation (GDPR) information and completed e-Learning on this. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for offsite shredding. And kept records and any paperwork confidential.

Safeguarding information including contact numbers for local safeguarding were available for the team. The pharmacist had undertaken level 2 CPPE training. And the team had completed training online. If a team member had a concern about a child or vulnerable adult, they would discuss this with the pharmacist in the first instance.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a suitably qualified and skilled team who work well together to manage the pharmacy's workload and services. 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 and two dispensers working in the pharmacy. One worked 37.5 hours weekly and the other 21 hours. In addition, there was an accuracy checking technician (ACT) who worked 18 hours a week at this pharmacy. She worked at another pharmacy on other days. One day a week there was second pharmacist cover. The pharmacy also had two other dispensers who worked 32.75 hours and 24.25 hours weekly. The pharmacy had recently lost a dispenser, but the pharmacy had now filled this post, with a qualified dispenser starting in October. In the meantime, the other dispensers had been working extra hours to assist. Certificates and qualifications were available for the team. And displayed at the counter.

The pharmacy team undertook training on a regular basis with some training mandatory and other modules optional. The team members completed training on the company's e-Learning and on 30-minute tutors. Recent training had included 'our just culture', digital pharmacy and reading the delivery standard operating procedures as a refresher. The pharmacy team undertook training in the pharmacy, with time given for this. The team undertook tests on topics covered in the training, each quarter. This ensured understanding of topics covered. The team had also undertaken training for services such as flu vaccinations, with this service due to commence shortly. And a dispenser was undertaking the Healthy Living training. The pharmacy team had targets for services such as MURs. These were achievable and done when they met the patient's needs.

The team members carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. They received performance reviews which gave the chance to receive feedback and discuss development needs. They said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist or area manager. 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 is safe and clean, and suitable for the pharmacy services it provides. People can have private conversations with a pharmacist or team member in the consultation room.

### Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team kept a cleaning rota to ensure they maintained this. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good 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. Members of the public could not access the dispensary as it had a gate at the end of the counter. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises. And they acknowledged and attended to them when they entered the pharmacy.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides its services using a range of safe working practices. And were good at making detailed notes to communicate any actions required. The pharmacy team members take steps to identify people taking some high-risk medicines. And provide these people with extra advice. The pharmacy team members dispense medicines into packs to help people remember to take them correctly. And the pharmacy delivers medicines. The pharmacy gets its medicines from reputable suppliers. It takes the right action if it receives any alerts that a medicine is no longer safe to use. The pharmacy displays some information about health-related topics.

### Inspector's evidence

The pharmacy was within a health centre. It had both a shared and separate entrance for people to use. The front door had broken, and the team had put a clear notice on the door which told people to go through the surgery to access the pharmacy. The pharmacy had reported the broken door to get it fixed as soon as possible. There were shutters between the surgery and pharmacy and the pharmacy controlled the shutters. It closed the shutters when it closed the pharmacy at the end of the day. The external entrance to the pharmacy had steps and a ramp which usually allowed ease of access for people. There was some customer seating. And a working hearing loop in place.

The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The pharmacy kept pharmacy only medicines in a glass cabinet with a notice saying, 'medicines in cabinet are not for self-selection'. The team assisted people if they wanted to purchase these items. And they gave them advice. The pharmacy had a health zone, but this had some chairs in front of it and some of the leaflets had fallen. So, it was not particularly informative or accessible for people.

The team signposted to other healthcare services such as Emergency Hormonal Contraception (EHC) as the pharmacist was waiting for the local training to complete the requirements of the Patient Group Directions (PGDs). The pharmacist had booked for the next course as the organisers had cancelled the previous one. The team referred people to the surgery or a nearby pharmacy. The pharmacy undertook Medicines Use Reviews (MUR) and the New Medicine service (NMS). People liked these, with several people benefitting from the review with improvements in inhaler technique. And some gained a better understanding about the most suitable time to take their medicines. The pharmacist advised of a MUR which resulted in a patient receiving his medication in a compliance pack. He was diabetic and had not been taking his medicines correctly. The pack had improved his compliance. The pharmacy referred people to the surgery for blood pressure checks as the surgery had a dedicated room for this service. The pharmacy provided flu vaccinations in the season.

The pharmacy supplied medicines to around 160 people in multi-compartment compliance packs to help them take their medicines. The team used the communication record sheets and printed notes from Patient Medication Records (PMR) and attached these to the records. These provided clear and detailed records of the action taken. The team completed the company Medisure patient record and highlighted on the sheets any different types of formulation. This assisted in avoiding any confusion or mix up in tablets such as modified release (m/r) or dispersible. The team had developed this from items which they had learnt had caused them confusion. They kept records of any changes in people's medication and had good audit trails of when they made any changes and who had authorised the

change. The team members supplied patient information leaflets (PILs) once with each four-week cycle. The pharmacy offered a substance misuse service. They were all supervised at 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 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 team noted on PIFs if any of the items dispensed was one of the look alike sound alike (LASA) drugs. This highlighted the extra vigilance when dispensing and checking.

When the pharmacy could not provide the product or quantity prescribed in 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. They had undertaken an audit. 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. People ordered their own medication except those in vulnerable groups who required assistance. The pharmacy team advised that since the Clinical Commissioning Group (CCG) had stopped the pharmacies ordering, the surgeries were considering people for the Repeat Dispensing service. The team reminded people when they would need to order their medicines to ensure they received them in time. And that people required to order any medication which was 'to be taken as required', so they would not run out. 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 stored medicines in an organised way, within the original manufacturers' packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. 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 obtained medicines from reputable sources. The team were aware of the Falsified Medicines Directive (FMD). And that a new computer system was being piloted in various pharmacies.



They advised that this was the start of the company making changes for FMD. The team were not sure when they would receive a new computer or when the company would be FMD ready. The team used appropriate medicinal waste bins for patient returned medication. The bins were collected 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 they discussed any alerts at the Monthly Patient Safety review.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

### 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 internet 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 controlled drugs. 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 pharmacy stored medication waiting collection on shelves where people could not see any confidential details. The team filed prescriptions 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 smartcard system to access people's records. And they used cordless phones for private conversations which allowed them to go away from earshot of the public when required.

### 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.  |