General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bouleuard Pharmacy, Boulevard Medical Practice, 116 Savile Park Road, HALIFAX, West Yorkshire, HX1 2ES

Pharmacy reference: 1105387

Type of pharmacy: Community

Date of inspection: 31/07/2019

Pharmacy context

This is a community pharmacy in a GP surgery in Halifax, West Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), a collection and delivery service, a substance misuse service and the NHS New Medicines Service (NMS).

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 suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law. The pharmacy team members have adequate tools available to them to safeguard vulnerable adults and children. The pharmacy team members discuss and learn from any errors they make while dispensing. And they take some steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy was large with ample bench space in the dispensary. It had a large open plan retail area which led straight into the dispensary. The pharmacist used a bench close to the pharmacy counter to do final checks on prescriptions, which helped him oversee sales of over-the-counter medicines and conversations between team members and people at the counter.

The pharmacy had a set of standard operating procedures (SOPs). And they were held in a ring binder. There was an index. And so, it was easy to find a specific SOP. The SOPs covered various processes including taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The superintendent pharmacist's office reviewed each SOP every two years. The next recorded review was scheduled for July 2020. This ensured that they were up to date. The pharmacy defined the roles of the pharmacy team members in a matrix at the front of the ring binder. All the team members had read and signed the SOPs that were relevant to their role. The matrix showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The final checker typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto a near miss log. The records contained details such as the date of the error and the team members involved. But the team members did not record why the error may have happened. And so, they may have missed out on the opportunity to learn from the mistake and make appropriate improvements. The team members discussed the error when it happened and tried to include all the team members present into the discussion. The near misses were analysed informally for any trends and patterns. But these findings were not documented. And so, it may have been difficult for the team to monitor if any improvement actions had succeeded. The team members had previously documented each near miss analysis into a report which the team members could access at any time. But they had struggled to continue the process since the regular pharmacist left the business in March 2019. The team members had recently discussed look alike sound alike medicines (LASAs). They were reminded to take extra care when dispensing these medicines, to prevent them being mixed up. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded these incidents electronically on a patient safety hub. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The reports included who was involved, what happened and why. An example of a recent incident involved the pharmacy mixing up two strengths of the same medicine. The team members discussed the error in a team meeting. And they were reminded to make sure they always dispensed from the prescription and not the dispensing labels.

The pharmacy did not advertise how the people who used the pharmacy could make comments, suggestions and complaints. The pharmacy collected feedback from people through an annual survey. The results of the latest annual survey were displayed in the retail area. An area identified for improvement was the advice the team gave people about living healthily. The team had made more effort to identify people who were suffering from cardiovascular conditions and speak to these people about their diet, weight management and quitting smoking.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And a sample seen was completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team was required to check the running balances against physical stock each month. The team members were sometimes unable to find the time to do this, but the checks were carried out at least once every two months. The running balance of methylphenidate 10mg tablets was checked and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy did not outline to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR).

The pharmacist on duty and the accuracy checking technician had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had no guidance readily available to them to help them manage and report a potential concern. But they did have the contact details of the local safeguarding teams. And they said that they would contact the local safeguarding teams for advice if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. It reviews staffing levels to ensure they remain appropriate. And the team members support each other whilst some of the team is in-training, to make sure it doesn't affect services to people. The team members openly discuss how to improve ways of working. And they regularly talk together about why mistakes happen, and how they can make improvements. The team members complete training when they can, to ensure their knowledge and skills are refreshed and up to date. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were a locum pharmacist, a full-time accuracy checking technician, two part-time trainee pharmacy assistants and a full-time NVQ2 qualified pharmacy assistant. The pharmacy did not employ any other staff. The pharmacy had been without a regular pharmacist since March 2019. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Cohens branches to cover planned and unplanned absences. The two trainee dispensers had started their roles in June 2019. The team said that the lack of a regular pharmacist had not impacted their services to people who used the pharmacy, but they were often pushed for time to complete several other tasks such as near miss analysis reports and controlled drug balance checks.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members were clear about the activities they could and could not do in the absence of a responsible pharmacist.

The pharmacy did not provide its team members with a structured process for them to keep their knowledge and skills up to date. But it encouraged them to read literature about pharmacy services and products that the pharmacy received in the post. This helped ensure they provided correct and relevant advice to people. The trainee pharmacy assistants did not receive time to complete training regularly during the working day. And they did a lot of their training in their own time. Both trainees said they received a lot of support from their more experienced colleagues and this was very helpful, particularly in the absence of a regular pharmacist. The pharmacy had a structured appraisal process designed to support its team members. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. And discuss their personal development. The team members were then set objectives to help them achieve their goals.

The team did not have regular, formal meetings. But as it was a small team, the team members discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team had

recently decided to separate ramipril tablets and capsules to prevent them being mixed up. The team were also given the chance to suggest feedback to improve the pharmacy's services. But no examples were provided.

The team members said they were able to discuss any professional concerns with the pharmacist or with the company head office personnel. They were aware the company had a whistleblowing policy. And so, the team could raise a concern anonymously. 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. The pharmacy also had a target for the number of prescription items dispensed. The team members did not feel under any pressure to achieve the targets but they always strived to do so.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and portrayed a highly professional image. The benches in the dispensary were kept tidy throughout the inspection. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It stores, sources and manages its medicines safely. The team members help people to safely take their high-risk medicines and they give them additional advice when it is necessary. They generally manage the risks associated with dispensing medicines in multi-compartmental compliance packs with suitable processes.

Inspector's evidence

The pharmacy was accessible from the adjacent car park via an automatic door. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the retail area. Seating was provided for people waiting for prescriptions.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. Another example was the use of a ‘pharmacist’ sticker which included a note to remind the person, to stop taking statins while they were on a course of antibiotics, as statins may stop the antibiotic from working properly. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The team used stickers to record the last day of hand out of CDs that did not require safe custody. This system prevented the team members from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy offered a service to deliver medicines to people’s homes. The records included a signature of receipt. And so, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The team members were aware of the risks associated with the supply of high-risk medicines such as warfarin, lithium and methotrexate. They were able to demonstrate how prescriptions for these medicines would be brought to the attention of the pharmacist, particularly if the medicine was new to a person. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy 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 person as the item was handed out. The team member handing the medicine out asked the patient to confirm that the product was what they were expecting. The team members were aware about the requirements of the valproate pregnancy prevention programme. And they demonstrated how the computer system printed a warning to check if a person met the criteria of the programme, each time a prescription for valproate was dispensed. The team members had access to a

support pack which contained warning stickers and leaflets which could be given to people. The team had not completed a check to see if any of its regular patients were prescribed valproate and met the requirements of the programme.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in three local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a rear bench. This was to make sure they weren't distracted while dispensing. The packs had backing sheets. And the sheets contained information to help people visually identify the medicines. The team did not routinely provide patient information leaflets with the packs. This is not in line with requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed every three months and it used stickers to highlight short-dated stock. It kept a record of the process. Some short-dated stickers were seen on the dispensary shelves. The team members recorded a list of medicines that were expiring over the next twelve months. They checked the book at the beginning of the relevant month and removed the medicines that were still stocked. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The team members were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). Correct scanners were installed but no software or a SOP was available to assist the team to comply with the directive. The team members had not received any training on how to follow the directive and they were unsure of when they expected the pharmacy to be compliant.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were found to be within the correct range. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. But the pharmacy did not keep a record of the action taken. And so, there was no audit trail in place which could be used to resolve a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy’s equipment is clean and safe to use. And the pharmacy generally protects people’s confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. There was no evidence of electrical equipment having been subjected to portable appliance testing. But the equipment appeared to be in good working order and well maintained.

Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn’t on view to the public. The computers were password protected. Cordless phones assisted the team in undertaking confidential conversations. Some confidential information was stored in the consultation room. And so, there was a risk that people using the room could see other people’s private information. The room was close to where the pharmacist completed final checks of prescriptions. And this reduced the risk of unauthorised access.

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.