General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 8 Bishops Auckland Shopping Park, Tindale Crescent, St. Helen Auckland, BISHOP AUCKLAND, County Durham, DL14 9FA

Pharmacy reference: 1116031

Type of pharmacy: Community

Date of inspection: 16/02/2023

Pharmacy context

The pharmacy is on a retail park near the centre of Bishop Auckland. It is open for 100 hours per week. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including a local minor ailments service (Pharmacy First), a service treating minor urinary tract infections (UTI) and the NHS New Medicine Service (NMS). The pharmacy delivers medicines to people's 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 adequately identifies and manages risks to its services. And it has documented procedures to help it provide services effectively. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss the mistakes they make to learn from them. But they don't always capture key information in these records to help aid future reflection and additional learning.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The company was in the process of updating its SOPs and migrating them to an online platform. Pharmacy team members received new and updated SOPs each month to read via the online training portal. Each procedure was accompanied by an assessment to test people's understanding. Pharmacy team members confirmed their understanding by passing the assessment. Pharmacy team members were clear about where the procedures were kept if they needed to refer to them. The pharmacy received a bulletin approximately every month from the company's professional standards team, called "The Professional Standard", which communicated professional issues and learning from across the organisation following analysis of near miss and errors. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed the front of each bulletin to record that they had done so. A recent example had been sharing learning from a dispensing incident where a vulnerable person had been provided with medicines that they should have collected several months previously, and the risks associated with uncollected prescriptions.

The pharmacy was providing a locally commissioned minor ailments service to people, called Pharmacy First. This enabled pharmacy team members to provide people with care for certain minor ailments, using treatment from an agreed formulary of over-the-counter medicines, without the need to see their GP. Minor ailments included thrush, head lice, minor eye infections, fungal skin infections, allergies and aches and pains. The pharmacy had considered the risks of delivering the blood pressure check service to people. Pharmacy team members explained how they assessed various risks, such as the suitability of the pharmacy's consultation room to deliver the service from, ensuring that people had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis. Team members gave a clear explanation of the risks of treating certain conditions. And they were clear about how and when they would refer to the pharmacist. The pharmacy was also able to help people suffering from minor urinary tract infections by providing and advice and treatment via a patient group direction (PGD). People were often referred to the pharmacy to access the service after being triaged by the GP surgery. The pharmacist carried out face-to-face consultations with people to make sure treatment could be provided safely and appropriately. The consultation often involved the pharmacist accessing people's NHS Summary Care Records (SCR) if they consented to this. The pharmacy provided people with appropriate treatment and then contacted them three and seven days after starting treatment to make sure the medicines were working to treat their infection. If treatment was not successful, the pharmacist was able to refer people for further care elsewhere. The pharmacy had up-to-date SOPs, a service level agreement and a signed private PGD document in place to help

them provide the service safely.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They used an electronic system to record their near miss errors. And the data collected was uploaded to a centralised system to help aid analysis. Team members made changes following errors. One example was separating and highlighting look-alike and sound-alike (LASA) medicines propranolol and prednisolone. Team members had also proactively highlighted other LASA medicines to help prevent mistakes from occurring. The pharmacy's electronic patient medication records (PMR) system used barcode scanning technology to help team members make sure they had selected the correct product from the shelves when dispensing. Team members explained the system had helped them to significantly reduce the number of wrong medicines, wrong strength and wrong form errors they made. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. A team member analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. Pharmacy team members were unable to access the electronic records during the inspection. So, the quality of error reporting could not be assessed. They explained a recent error that had occurred where someone had been provided with someone else's medicines. Following investigation, they found that a team member had not followed the pharmacy's correct procedure when handing out the prescriptions to confirm the person's identity. The person involved received further training and the rest of the team were reminded about the importance of following the pharmacy's documented processes.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. And it had materials available for people in the retail area about how to provide feedback. Pharmacy team members explained feedback was usually collected verbally and by using comment cards given to people at the pharmacy counter. The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained a responsible pharmacist record, which was accurately completed and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. They explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training on this each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training each year.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve services and make the pharmacy safer. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the team members present were a relief pharmacist, a qualified dispenser and a trainee dispenser. They were observed to manage the workload effectively. Team members completed mandatory e-learning modules regularly. The latest modules included training on information governance and cancer. And they also regularly discussed learning topics informally with each other. Team members regularly read new and revised standard operating procedures (SOPs) via the company's online training platform. And were required to pass a short test after reading each SOP to confirm their understanding. The pharmacy had an appraisal process in place for pharmacy team members. Team members had a meeting every year with their manager to discuss their performance and learning needs. And they set objectives to address any learning needs identified. Team members explained they would also raise any learning needs informally with the pharmacy manager, who would support them to access the right resources to complete their learning. The relief pharmacist had not received a performance appraisal with their manager in several years. They explained they would raise any needs informally with other pharmacist colleagues if they felt they needed support.

Pharmacy team members explained how they would raise professional concerns with their pharmacist, store manager or area manager. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. Pharmacy team members knew how to access the procedure. Pharmacy team members communicated openly during the inspection. They were asked to achieved targets in various areas of the business, for example the number of prescription items dispensed, and the number of services provided. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely. And explained they were comfortable to have conversations with their area manager if they did not achieve their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy’s floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. Team members also kept the room locked when it was not being used to prevent unauthorised access. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink which had hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Overall, the pharmacy's appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people, including people who use wheelchairs. The pharmacy has systems in place to help make sure it provides its services safely and effectively. These include processes to help ensure people's medicines are suitable for them and that they receive appropriate advice. It sources its medicines appropriately. And it generally stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the retail park through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. And they signed a quadrant printed on the prescription. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. Pharmacy team members used various alert cards to highlight different aspects of a prescription. These included highlighting an item that required storage in a fridge, a controlled drug (CD) and some high-risk medicines such as warfarin and sodium valproate. Pharmacy team members also attached a sticker to prescription bags containing CDs. They wrote the expiry date of the prescription on the sticker. This was to help prevent the medicines being given out after the prescription had expired. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them understand the risks of taking valproate. Pharmacy team members were aware of the necessary steps to take and the questions to ask people to make sure they supplied medicines to people safely over the counter. They clearly explained their limitations and gave examples of the types of requests they would refer to the pharmacist. These included referring requests for chloramphenicol and pseudoephedrine. A team member was observed responding to a request for Solpadine Max. They questioned the person appropriately. They provided them with good counselling about how to take the medicines safely and about the risks of addiction ad dependence when using medicines that contain codeine.

The pharmacy supplied medicines for people in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs 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. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). Team members kept records of communications they had with the GP surgeries and others about people's medicines, to help resolve future queries quickly. The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for several other local stores. The pharmacy used an electronic system to manage and record deliveries and it uploaded information to the driver's handheld device. Pharmacy

team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to four months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items during the month of their expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

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 it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.