General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 196-199 High Street, Lincoln, Lincolnshire, LN5 7AL

Pharmacy reference: 9011138

Type of pharmacy: Community

Date of inspection: 07/01/2020

Pharmacy context

This is a community pharmacy in Lincoln city centre. The pharmacy relocated to a new building in April 2019. It is part of a larger health and beauty store. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. And it provides some private services including vaccination services and a skin scanning service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to care homes. 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
1. Governance	Standards met	1.2	Good practice	The pharmacy has some good processes for managing safety. And its team members are committed to adapting their approach to reviewing risk and sharing learning to help continuously drive improvement.
		1.3	Good practice	Pharmacy team members have clearly defined roles and responsibilities. And the pharmacy manages the risks associated with delegating its tasks well, through keeping audit trails.
2. Staff	Good practice	2.2	Good practice	The pharmacy has good learning and development strategies which encourage pharmacy team members to expand their knowledge and skills. And pharmacy team members receive protected learning time.
		2.4	Good practice	Pharmacy team members engage regularly in team discussions. They are enthusiastic about their roles. And they understand the importance of sharing learning to improve safety across the pharmacy.
		2.5	Good practice	The pharmacy encourages feedback from its team members. And it demonstrates how it listens to and responds to feedback to inform its safety processes.
3. Premises	Standards met	3.2	Good practice	Pharmacy team members actively promote the use of the pharmacy's consultation rooms to people. And these rooms are suitably sound proof and are fitted to a high standard.
4. Services, including medicines management	Standards met	4.1	Good practice	Pharmacy team members are committed to engaging with people about their health and wellbeing. They show how they reach out to people through the pharmacy's health campaigns. And through the pharmacy partnering with other specialist organisations to provide innovative services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services. It has some good processes for managing safety. And its team members are committed to adapting their approach to reviewing risk and sharing learning to help continuously drive improvement. Pharmacy team members have clearly defined roles and responsibilities. And the pharmacy manages the risks associated with delegating its tasks well, through keeping audit trails. It keeps people's private information secure. And it keeps all records it must by law. It has the necessary arrangements in place to protect the health and wellbeing of vulnerable people. The pharmacy responds appropriately to the feedback it receives from people using its services. And it shares this feedback with its team members.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The pharmacy superintendent's team reviewed the SOPs on a two-year rolling rota. Roles and responsibilities of the pharmacy team were set out within SOPs. Pharmacy team members explained how updated and new SOPs were brought to their attention by a manager. A sample of training records confirmed that members of the team had completed training associated with their roles. And training matrixes within the SOP folders supported managers in ensuring this training was kept up to date. Pharmacy team members completed regular quizzes to test their understanding of SOPs. A team member explained these would normally be completed a month or so after team members had read the SOP initially to help confirm their understanding of it. Pharmacy team members on duty were seen working in accordance with SOPs. For example, when selling an over-the-counter medicine.

A member of the team clearly explained the tasks which could not take place if the responsible pharmacist (RP) took absence from the premises. And the same team member was confident when explaining what action she would take when posed with a hypothetical scenario about a request for an over-the-counter medicine which may be unsuitable for a person. There were two accuracy checking pharmacy technicians (ACTs) in the team. And the ACTs discussed their roles. Their skills were used to support trainee members of the team. And they held additional accountabilities such as supporting patient safety reviews. Both ACTs provided examples of how they applied their professional judgement when undertaking the accuracy check of a medicine. For example, referring a prescription to a pharmacist if there was no recorded clinical check. And raising queries about doses and medicine regimens if concerns arose. One example of a recent ACT led intervention had led to a dose of a medicine being changed by the prescriber. The pharmacy management team had also received specific training and mentoring to support them in the management aspects of their role.

The pharmacy had an up-to-date business continuity plan in place. Managers undertook daily, weekly and monthly clinical governance checks of the pharmacy environment. This helped provide ongoing assurance that the pharmacy was operating safely and effectively. It had three dispensaries in operation. The main dispensary was situated alongside the healthcare counter. Pharmacy team members working in this dispensary managed acute workload and repeat prescriptions. The care home dispensary was located on the first floor of the building. And a small Medisure dispensary was also located on this floor. The Medisure dispensary was used to complete tasks associated with the supply of medicines in multi-compartment compliance packs. Workflow in each dispensary was efficient and

appeared to be well managed. For example, trackers in the care home and Medisure dispensary helped ensure medicines were dispensed ahead of collection and delivery dates.

The care home service dispensary was technician led. Pharmacists attended the dispensary at least twice daily to complete clinical checks of prescriptions. And to provide any clinical interventions required. The dispensary used a colour coded tray system to alert pharmacists of queries. A red tray was used to manage queries and matters for urgent attention relating to the monthly supply of medication to homes. A yellow tray was used to manage queries and matters for urgent attention associated with interim medication. The pharmacist was required to check the contents of the tray and completed an audit sheet to confirm these checks and any outstanding actions had been completed twice daily. And a member of the care home team was assigned to ensure the contents of each tray had been reviewed by a pharmacist. Audit sheets confirmed twice daily checks consistently took place.

The pharmacy team used 'Pharmacist information Forms' (PIFs) to communicate key messages to pharmacists and other team members, such as changes to medicine regimens, interactions and eligibility for services. The team retained PIFs with prescription forms to inform counselling required when handing-out medicines. A random check of the prescription retrieval filing system in the main dispensary found PIFs attached to all selected prescriptions. Random checks of assembled medicines waiting to be checked in the care home dispensary found specialist care service PIFs with all prescriptions. PIFs were completed in accordance with details within the SOPs.

There was a near-miss error reporting procedure in place. And pharmacy team members identified how they discussed their own mistakes with a pharmacist or ACT. Pharmacy team members contributed to recording mistakes and near-miss error reporting forms prompted reflection of the mistake, such as contributory factors. The main dispensary team and Medisure team used standardised templates to record details of their near misses. The care home dispensary had introduced some additional templates to encourage the team to reflect on both the contributory factors and the possible consequence of the mistake. The ACTs explained how the new forms had been introduced due to a rising number of near-misses despite regular actions being taken to help reduce risk in response to trends. The new process had encouraged team members to reflect on their practice and pay more attention to the importance of checking their work prior to submitting it for a final accuracy check. The pharmacy recorded dispensing incidents electronically through the internal 'Pharmacy Incident and Event Reporting System' (PIERS). Evidence of reporting was available. And pharmacy team members were knowledgeable about the actions taken to reduce risks following an incident.

The care home team had increased the frequency of their patient safety reviews to twice monthly for a short period following the increase in near-miss errors. This had helped the team focus on current trends and how to manage them. The team identified three main learning points during the review and these were displayed in the dispensary for staff to refer to. An idea from a team member had been taken onboard by the main dispensary manager. Team members working in the main dispensary and Medisure dispensary now received a personalised breakdown of their near-misses along with personalised action points. These action points were in addition to shared learning the team identified. For example, one team members actions was to ensure focus was maintained when labelling batches of prescriptions, another team member's actions were around double-checking quantities when assembling medicines. Several pharmacy team members explained how this additional feedback was useful in supporting them in their own development, particularly as some staff worked part-time and may not be on duty at the time a mistake was discovered.

The pharmacy advertised its complaints procedure clearly within its practice leaflet. And pharmacy team members could explain how they would manage feedback or a complaint. A pharmacy team

member discussed the escalation process for concerns if people were not happy with the response provided. The pharmacy promoted feedback through making 'Community Pharmacy Patient Questionnaires' available to people. And it advertised an online questionnaire. A notice board in the staff area of the premises contained no recent complaints. And a noticeboard for compliments was observed to contain a number of examples submitted by people using the pharmacy. A team member explained how the pharmacy had removed the need for people to queue in the 'express lane' when picking up a repeat prescription, as they had received feedback about the lane not working as intended.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. And this was updated in a timely manner when the RP changed midway through the inspection. Entries in the RP record followed legal requirements. A sample of the controlled drug (CD) register found that it met legal requirements. The pharmacy kept running balances in the register. Balance checks of the register against physical stock took place weekly. A physical balance check of Oxypro 10mg prolonged release tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. The team entered returns in the register on the date of receipt. The pharmacy held the Prescription Only Medicine (POM) register electronically. Records complied with legal requirements. The pharmacy completed full audit trails on certificates of conformity for unlicensed medicines as per the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA)

The pharmacy held records containing personal identifiable information in staff only areas of the pharmacy. It displayed a privacy notice. The team completed annual information governance training. And this learning included the requirements of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS data security and protection (DSP) toolkit as required. Pharmacy team members put confidential waste in designated blue bags in the dispensaries. These were sealed and sent for secure destruction periodically.

All pharmacy team members completed mandatory safeguarding training. And pharmacy professionals had completed level two learning through the Centre for Pharmacy Postgraduate Education (CPPE). Members of the team spoken to about safeguarding were able to identify how they would recognise and report a safeguarding concern. The pharmacy had up-to-date procedures in place for safeguarding vulnerable people. And contact details for local safeguarding agencies were available. A pharmacy team member explained how people were informed of their choice to have a chaperone present with them in the consultation room if preferred. And the pharmacy's chaperone policy was advertised.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It reviews its staffing levels and the skill mix of its team to ensure they remain appropriate. It has good learning and development strategies which encourage pharmacy team members to expand their knowledge and skills. And pharmacy team members receive protected learning time. They engage regularly in team discussions. And they are enthusiastic about their roles. They understand the importance of sharing learning to improve safety across the pharmacy. The pharmacy encourages feedback from its team members. And it demonstrates how it listens to and responds to feedback to inform its safety processes.

Inspector's evidence

In total the pharmacy employed two regular pharmacists, two ACTs, 16 qualified dispensers (pharmacy advisors), seven trainee dispensers and four healthcare assistants. One dispenser (the Care Home Service Partner) was enrolled on an accredited level three course and planned to register as a pharmacy technician upon completion of this course. Company employed delivery drivers provided the prescription collection and delivery service. The manager provided an overview of staffing levels on a typical day. This included either two pharmacists and two ACTs or three pharmacists and one ACT working alongside three dispensers in the main dispensary, a dispenser in the Medisure dispensary, the Care Home Service Partner, four-five dispensers in the care home dispensary and one-two healthcare assistants. The care home dispensary team was managed by one assistant manager and another assistant manager managed the Medisure and main dispensary team. Both assistant managers and the store manager were qualified dispensers.

Changes to the staffing rota were notified to the team in a timely manner and displayed in the main dispensary. Some concern about secondary cover for the multi-compartment compliance pack service was noted during the inspection as one member of the team was moving to a zero-hour contract. The manager shared upcoming arrangements planned to cover annual leave and succession planning. The manager confirmed some details of this cover was due to be shared with relevant team members.

The pharmacy was busy throughout the inspection. There was enough staff on duty to cope with the demand in services. And pharmacy team members working at the front work stations appropriately asked their colleagues for support when queues started to form. Pharmacy team members were observed working well together throughout the inspection. For example, on the day of inspection, a newly qualified pharmacist and a pharmacy assistant who had returned to work from maternity leave were being well supported. The pharmacy assistant explained she had completed a tour of the new premises and a short shift in December 2020 to assist her in returning to work. All store staff were encouraged to provide positive feedback to their colleagues. A noticeboard in the staff only area of the store highlighted some positive comments received about the pharmacy team from colleagues. The pharmacy had some targets for the services it provided. These were achievable and pharmacy team members supported pharmacists in delivering these services by highlighting people's eligibility for a service on the PIF. A locum pharmacist on duty explained the pharmacy did not set any specific targets for him. But he was encouraged to contribute to services. For example, by completing Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations.

Each pharmacy team had a training matrix to support pharmacy team members in completing continual learning associated with their roles. And this was updated monthly. The pharmacy provided 30 minutes of protected learning time each week for this. The trainee pharmacy technician received additional protected learning time to support her in completing her course. Continual learning included the completion of regular 'Tutor' modules on a range of healthcare topics, SOP quizzes, healthy living topics and regular e-learning. Certificates of training for some CPPE modules were seen. This included learning associated with risk management, safeguarding vulnerable people and sepsis. The pharmacy's superintendent pharmacist's office provided regular newsletters which prompted reading and discussion about patient safety. Pharmacy team members received regular verbal feedback and scheduled learning and performance reviews with their managers.

Pharmacy team members engaged in daily briefings to help organise workload, highlight areas of priority and discuss any learning from the previous day. Both pharmacy teams held team briefings every Monday. Pharmacy team members from the care home team provided cover in the main dispensary to allow all members of the main dispensary team on duty to attend their team meeting. A healthcare assistant explained how her manager went through details of the meeting with her personally as she did not work Mondays. Teams discussed patient safety reviews within these meetings. And also, through one-to-one feedback with the ACTs and managers. Pharmacy team members were confident when describing learning following these reviews. For example, a dispenser explained how the main dispensary team had been asked to review 'Just Culture' e-learning. She explained how this e-learning encouraged people to think about the person behind the prescription and as a result led to an increased focus on dispensing accuracy.

The pharmacy had a whistleblowing policy in place. This was advertised prominently. All pharmacy team members spoken to confirmed they were confident in providing feedback. And they knew how to escalate a concern if they needed to. There were some positive examples of feedback being used to support team members personally. And some examples of feedback being used to support safety across the pharmacy were demonstrated. For example, the care home team had implemented a new system for managing interim prescriptions. This followed concerns about the pressure associated with this part of the service and the potential for mistakes caused by this increased pressure. The new process used a priority system to dispense the interim prescriptions. And ahead of making the changes the details of the new system was shared with care homes. Pharmacy team members provided examples of how the system had increased safety both in the pharmacy and at care homes. This was because it involved checks to confirm the urgency of each prescription. These checks had led the team to identify occasions when interim medicines were not required until the start of the next cycle. The team also carried out routine checks of any additional medicines on prescription forms, other than those written on the MAR sheet. These checks had led to some prescriptions not being dispensed as homes had confirmed the medicine was not required. Pharmacy team members explained how this increased safety as the homes were only receiving the medicines required. And it also saved NHS money.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. Pharmacy team members actively promote the use of the pharmacy's consultation rooms to people. And these rooms are suitably sound proof and are fitted to a high standard.

Inspector's evidence

The pharmacy was professional in appearance. It was secure and well maintained. Pharmacy team members reported maintenance issues to a designated help-desk. There were no outstanding maintenance issues found during the inspection. The pharmacy was clean and organised. Antibacterial soap and paper towels were available close to designated hand washing sinks.

The public area was fitted with wide-spaced aisles which allowed easy access for people using wheelchairs and pushchairs. There were two sound proof consultation rooms available for people to speak in private to a member of the pharmacy team. These rooms were fitted to a high standard. For example, both had air conditioning units. And they were a good size. The rooms provided a suitable environment for providing the pharmacy's extensive range of consultation services. And they were observed being used throughout the inspection to provide these services. Pharmacy team members explained how having two rooms available meant services were more accessible to people. And the pharmacy had at least two pharmacists on duty six days a week to provide clinical services. A semi-private hatch to the side of the dispensary provided additional discretion to people accessing the pharmacy for the supervised consumption service.

The dispensaries were a suitable size for the level of activity carried out in each. Work benches in each dispensary were free from unnecessary clutter. And shelving above work benches were used to hold tubs and trays of assembled medicines waiting to be accuracy checked. Floor spaces across the premises were free from trip hazards. Air conditioning was available in each dispensary. And lighting throughout the premises was bright.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers access to an extended range of services and ensures these services are easily accessible to people. Pharmacy team members are committed to engaging with people about their health and wellbeing. They show how they reach out to people through the pharmacy's health campaigns. And through the pharmacy partnering with other specialist organisations to provide innovative services. The pharmacy has records and systems in place to make sure people get the right medicines at the right time. It obtains its medicines from reputable sources. And it stores these medicines safely and securely.

Inspector's evidence

The store was accessible through automatic doors at two entrances on different sides of the building. The pharmacy was located at the back of the store, next to the opticians. It displayed details of its opening times and services. The pharmacy used an area close to its consultation rooms to display details of healthy living campaigns. The campaign on the day of inspection focussed on the benefits of reducing alcohol intake through completing 'Dry January'. Other healthy living information at the healthcare counter invited people to engage in a quiz about their lifestyle habits and focus on making positive changes for the year ahead. Pharmacy team members explained how they would signpost people to other pharmacies or healthcare providers if they were unable to provide a service.

There was evidence of beneficial outcomes from health campaigns and pharmacy audits. For example, a campaign relating to support for carers had resulted in six people coming forward and requesting further information. Each person had been signposted to the appropriate organisation and pharmacy team members had recorded the details of these interventions. Clinical audits completed within the last six months included audits for high-risk medicines and audits associated with diabetes. The pharmacy had made its flu vaccination service highly accessible to people. It had done this by having a dedicated pharmacist providing continual access to appointments during the peak season in one of the pharmacy's consultation rooms. Up-to-date and legally valid patient group directions (PGDs) were available to support the PGD services. The pharmacy's regular pharmacists were not on duty to provide specific examples of outcomes from services such as MURs and NMS.

The pharmacy's skin screening service was accessed regularly. An appointment for mole scanning took place during the inspection. And the pharmacy team member providing the service gave an oversight of how it was managed. The service was provided in association with ScreenCancer. It provided people with an opportunity to have their moles checked by a specialist dermatologist. And it involved a trained member of the team taking images of the photographs and sending them to ScreenCancer for analysis following a consultation and signed consent. The pharmacy team member explained she always telephoned ScreenCancer when the person was still in the pharmacy to ensure the quality of the images sent were appropriate. The person received their results within a week and received a remote consultation with a ScreenCancer dermatology nurse if further action was required.

The pharmacy team members identified high-risk medicines and highlighted these prescriptions through the use of bright laminated cards. The cards included details of monitoring checks and counselling required when supplying these medicines. And examples of recording monitoring checks

were provided. A team member in the care home dispensary confirmed high-risk medicines such as warfarin were not supplied unless appropriate monitoring records had been provided to the pharmacy. Pharmacy team members in each dispensary demonstrated the requirement to identify people taking valproate preparations. They showed a good insight of the requirements of the Valproate Pregnancy Prevention Programme (PPP). And demonstrated how people's medication records had been used to record confirmation that people in the high-risk group had appropriate pregnancy prevention plans in place. People in the high-risk group were suitably counselled and provided with valproate warning cards.

One pharmacy team member managed the supply of medicines in multi-compartment compliance packs. Support for the service was provided by another team member. Pharmacy team members either recorded information about medication changes and queries through leaving notes on people's medication records, verbally handing information over to the dispenser or leaving a note on the main workbench in the Medisure room. This process was not aligned with the SOP for the service which specified the need to record information in a 'communication book'. The opportunity was taken to review details of the SOP during the inspection and a communications book was immediately implemented. Details of how the book was to be used was shared with team members in the main dispensary, and it was observed being used by one team member during the inspection. The manager confirmed he would share further learning about the new process to other team members moving forward. The service was managed over a four-week rolling cycle. And a Medisure progress record was in use to provide an audit trail throughout the four-week cycle. Each person receiving their medicines in multi-compartment compliance packs had their own individual record in place. These records were generally updated when changes to medication regimens took place. But there were some examples of crossing-out on the records without any further information of the changes made. A sample of assembled packs included full dispensing audit trails and descriptions of the medicines inside to help people recognise them. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. And it recorded the start date on each pack to help people manage their medicines.

An assistant manager led the care home dispensary alongside the Care Home Service Partner and two ACTs. A pharmacist provided regular site visits to care homes to support them in managing their medicines. The pharmacy supplied all homes with medicines in original packs. And pharmacy team members discussed how they had implemented changes from dispensing in multi-compartment compliance packs to original packs approximately a year ago. The ACTs explained how these changes had led to them developing their skills further. The pharmacy checked prescriptions received against re-ordering Medication Administration Record (MAR) sheets returned from homes. Queries were recorded and sent to the homes for missing prescriptions or changes to medication regimens. And the team used carbon-copied communication sheets to record queries and conversations with care home teams. Prescriptions were clinically checked by a pharmacist following a member of the team 'priming' the prescription. The priming process included completing PIFs and producing MAR sheets. Pharmacy team members picked medicines against the prescription and each person's prescription and medicines were held in individual trays and tubs throughout the dispensing process. ACTs then bagged medication for each person in a home separately and transferred the bags to totes ready for delivery.

The care home team managed interim prescriptions efficiently. The changes made to the service meant that acute prescriptions for urgent medicines such as antibiotics and painkillers were dispensed the same day. And prescriptions for non-urgent medicines were sent within an agreed timescale with each home. The team member assigned to administration duties each day was responsible for contacting care homes and agreeing this timescale. The pharmacy provided MAR sheets when dispensing interim medicines. It retained faxed prescriptions and physically attached dispensing labels to these

prescriptions. A team member explained how this supported the team in ensuring they received the original prescription in a timely manner. The pharmacy did not dispense any CDs against faxed prescriptions.

In the main dispensary team members used tubs throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Prescriptions for people waiting in the pharmacy were brought to the direct attention of a pharmacist. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also signed a 'quad grid' on prescription forms to indicate who had assembled the medicines, clinically checked the prescription, accuracy checked the medicines and handed out the medicines. In the care home dispensary, the hand out section of the quad grid was used to indicate who had primed the prescription.

The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service and people signed an electronic point of delivery device (EPOD) to confirm they had received their medicine. The pharmacy used cool units to transport cold chain medicines through its delivery service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members spoken to about the Falsified Medicines Directive (FMD) were not aware of the requirements of the directive. They understood that a new computer software programme was being rolled out by the company which would assist with compliance in the long-term. The pharmacy had not received any dates for the implementation of the new system. The team was aware it would be one of the last waves of pharmacies to receive the upgrade due to being a pharmacy which provided care home services. A discussion took place about the importance of checking tamper-proof seals when managing medicines in FMD compliant packaging.

The pharmacy stored Pharmacy (P) medicines behind the healthcare counter and on designated shelves in the public area. Signage and restrictions prevented any sales of these medicines taking place at any tills other than those on the healthcare counter. This meant a pharmacist could supervise sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. The pharmacy team followed a date checking rota. This was comprehensive and covered all areas of the pharmacy including the Medisure dispensary and consultation rooms. The team annotated details of opening dates on bottles of liquid medicines. There were no out-of-date medicines found during random checks of stock in each dispensary. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. Medicine storage arrangements in the cabinets was orderly. Substance misuse medicines were pre-assembled and stored securely. The pre-assembly of these medicines against the current prescription reduced the risk of workload pressure when a person attended for their medicine. The pharmacy held assembled CDs in clear bags with details of the prescription's expiry date annotated clearly on the bag. The pharmacy also highlighted prescriptions for these medicines to prompt additional safety and security checks during the dispensing process.

The pharmacy had six fridges in total. Four held stock on the date of inspection. Pharmacy team members explained how the fridge in the Medisure dispensary and a fridge in a consultation room were used as temporary storage areas when stock levels of cold chain medicines increased during peak flu vaccination season. All fridges were clean and stock inside them was organised. The pharmacy stored

assembled cold chain medicines within clear bags inside the fridges. This meant that the contents of the bag were easily identifiable. And it prompted additional checks of the medicine against the prescription prior to hand out. The team checked the temperature of the fridges in use daily. Temperature records confirmed that the fridges were operating between two and eight degrees Celsius as required. And pharmacy team members confirmed they checked the two empty fridges prior to them being put into use. And daily when they were in use.

The pharmacy received drug alerts through the intranet. Details of alerts were checked across all three dispensaries prior to the team completing an audit trail confirming the alert had been read and acted upon. But some adrenaline autopens subject to a recent recall were found in one of the pharmacy's consultation rooms. Appropriate action had been taken to remove and replace the adrenaline autopens with alternative equipment in consultation room one. But appropriate checks of consultation room two had been missed. A pharmacist and the store manager confirmed consultation room one was the room designated for providing the vaccination services. The pharmacist removed the pens from the second room immediately and made alternative equipment available. A discussion took place about the importance of ensuring all possible stock holding areas were checked when managing this type of alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs for providing its services. It monitors equipment to ensure it remains safe to use. And its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Internet access and intranet access provided further reference resources including access to Medicines Complete. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. Cylinders for use with methadone were clearly marked and stored separately. Counting equipment for tablets and capsules was available. This included separate equipment for counting cytotoxic medicines. The pharmacy's electrical equipment was subject to portable appliance checks periodically. Equipment to support the vaccination services and skin scanning service was stored securely in locked consultation rooms. A fridge in one of the consultation rooms was available for the temporary storage of vaccinations during flu vaccination season.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Pharmacy team members had personal NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection and delivery in a retrieval system behind the healthcare counter. Personal information on bag labels could not be seen from the public area. It stored prescriptions relating to the assembled bags of medicines safely. General workflow meant that pharmacy team members managed acute workload at workstations on the front dispensing bench. They removed any personal identifiable information between serving people and when walking away from the area. And a queuing system guided people visiting the pharmacy to stand back from the counter until called forward. The pharmacy had cordless telephone handsets. Pharmacy team members moved to the back of the dispensary when speaking with people on the phone. This meant that the privacy of the caller 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.