General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 47-49 Gloucester Road, Bishopston, BRISTOL, Avon, BS7 8AD

Pharmacy reference: 1028641

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

This is a community pharmacy in a vibrant shopping area in the northern suburbs of the city of Bristol. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy is appropriately insured to protect people if things so wrong. It keeps the up-to-date records that it must by law. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. All dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a recent error where a controlled drug (CD) had been omitted from a person's medicines. Whilst a dedicated CD card was included in the tub of medicines, it had been identified that possibly, the error was due to the recent re-scheduling of gabapentin and pregabalin that do not require safe custody. The omitted medicine was morphine, a schedule 2 controlled drug requiring safe custody. Because of the error, it was now written on the pharmacist information form (PIF), that should accompany all prescriptions according to the company procedures, whether the CD was in the cabinet. Near misses were recorded but insufficient information was documented to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. It had been identified in September 2019, that several mistakes were quantity errors. No specific actions had been put in place to reduce recurrences. However, the risk of picking errors with 'look alike, sound alike' drugs was identified such as propranolol and prednisolone. The superintendent's office had recently sent a laminated sheet containing some of these drugs such as quinine, quetiapine, atenolol, and allopurinol. This was displayed near the computer monitors with instructions that these should be highlighted on the PIFs that were attached to all prescriptions. In addition, the pharmacy had made a local addition, azithromycin and azathioprine because of picking issues with these. The superintendent's office sent monthly bulletins which were read and signed by all the staff but the recent one was not displayed for easy reference by the staff.

The dispensary was extremely limited in size. The staff did their best to manage this small space. Shelves above the small checking area were used for prescriptions waiting to be checked in order to keep the bench as clear as possible. Only one patient had their medicines assembled into a multi-compartment compliance aid because of the space constraints. There was however, a large amount of underutilised space upstairs in the pharmacy. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was no displayed sales protocol for medicines sales specific to the store. There was a small card about the protocol displayed by the till. Care cards, according to company procedures, were not displayed on the shelves for the sale of those products which should be referred to the pharmacist. The pharmacist did say that the staff were prompted by a message on the till to refer the sale of certain items, such as Levonelle and Viagra Connect to the pharmacist. A NVQ2 qualified dispenser said that she would refer anything to the pharmacist that she was unsure of, as well as, requests for medicines for children under two, those on prescribed medicines and diabetic customers.

The staff knew about the complaints procedure and said that feedback on all concerns was encouraged. The company operated a random feedback procedure and some till receipts gave instructions on how to provide feedback and raise concerns. All feedback was collated by the company's head office and passed onto the store if appropriate. In addition, there were cards close to the till giving customers instructions on how to provide feedback. However, the store manager said that they generally received verbal feedback. A pharmacy specific customer satisfaction survey was done. In the 2019 survey, 94.8 % of people who completed the questionnaire rated the pharmacy as excellent or very good overall. 2.1% of customers had mentioned having a clear layout of the pharmacy. The pharmacy team said that there had been no change as a result of this feedback.

Current public liability and indemnity insurance was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the company's procedures for the safeguarding of both children and vulnerable adults. The pharmacist, a locum, had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. The staff are encouraged to keep their skills up to date but they generally do this in their lunch breaks. Formal appraisals for the team members are behind schedule and so any gaps in their knowledge and skills may not be identified. And, whilst they feel able to raise any issues, there are no regular meetings. This means that some members may not be aware of recent mistakes or other concerns.

Inspector's evidence

The pharmacy was in a vibrant shopping area in the northern suburbs of the city of Bristol. They dispensed relatively few NHS prescription items each month. Because of the limited size of the dispensary, medicines were not routinely assembled into multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was two part-time pharmacists or locums and three full-time NVQ2 qualified dispensers, one of whom was the manager and one not seen (on holiday). Additional pharmacist cover was provided for a one-hour lunch period to allow the pharmacist a lunch-break. The medicine counter was seen to be busy over the lunch period. The pharmacy was actively trying to recruit a further part-time staff member. A part-time member of staff had left at the end of September 2019. Since this time, due to planned holidays, the staffing over the last few weeks had generally been one pharmacist and two other members of staff. The recruitment of a part-time staff member should ease this situation. And, this would also help with the limited flexibility for the staff to cover any unplanned absences. Planned leave was booked well in advance and generally only one member of staff could be off at one time.

There was no full-time employed pharmacist. A NVQ2 dispenser was the manager. Staff performance was monitored, reviewed and discussed informally throughout the year but formal annual appraisals were well behind schedule.

The staff were encouraged with learning and development and completed compulsory e-Learning mainly during their lunch-break. They were not completing the company’s 30-minute tutors. There were no formal staff meetings and the patient safety review was not discussed with the staff. The employed staff member seen did however say that she felt able to raise any concerns. The pharmacist seen, a locum, said that he tried to do two medicines use reviews (MURs) every day. He said that he only did clinically appropriate reviews and did not feel unduly pressured to do these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional. The consultation room is signposted so that it is clear to people that there is somewhere private for them to talk. But, the room is not well secured from the outside and this could pose a risk, particularly to children. The pharmacy would also benefit from better use of the available space and some routine maintenance.

Inspector's evidence

The pharmacy was generally well laid out and presented a professional image. But, the dispensing area was extremely limited in size and it could be tidier and more organsied. There was a large amount of underutilised space upstairs in the pharmacy. The retail area of the pharmacy was clean but all other areas needed dusting. A door handle from the staff area to behind the medicine counter was broken. One of the front glass doors was not operational. It was sticking on a slight incline. The waste medicine bins were difficult to access. The door to the consultation room could be secured from the inside, at the top. But, whilst a hole had been drilled to secure it from the outside, no mechanism to enable this, had been installed. The staff reported that children often played with the door. And, during the flu vaccination service season, they had to remove the sharps bin from the room to prevent any accidental issues.

The consultation room was relatively small but there was a folding table, and, the door opened outwards. This meant that a patient should be able to be placed in the recovery position, if necessary and access by the emergency services should not be impeded. The room had no computer for Medicines Use Reviews. However, the staff reported that they will soon be provided with one in order to undertake the new Community Pharmacy Consultation Service (CPCS). The pharmacy computer screen was not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

All people can access the services the pharmacy offers. The services are generally effectively managed to make sure that they are provided safely. The pharmacy team members make sure that people have the information that they need to take their medicines properly. They intervene if they are worried. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with a push-button opening front door. There was access to Google translate on the pharmacy computers and on the pharmacy's iPad for use by non-English speakers. The pharmacy staff seen were not sure if they could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of methadone and buprenorphine, needle exchange, emergency hormonal contraception (EHC) (some accredited pharmacists) and seasonal flu vaccinations. The latter was also provided under a private scheme as was malaria prophylaxis by a regular part-time pharmacist (not seen). The services were well displayed and the staff were aware of the services offered.

The regular part-time pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. She had also completed suitable training for the provision of the free NHS EHC service.

Just a few substance misuse patients had their medicines supervised. There was a dedicated folder for these patients but there were no telephone numbers of the key workers. The staff were not aware of the local shared care guidelines, the Recovery Orientated Drugs and Alcohol Service (ROADs) guidance. It was seen that a patient was given 80ml of methadone with no water offered to reduce the likelihood of diversion. The inspector sent the pharmacy the ROADS guidelines.

Most domiciliary patients having their medicines in compliance aids had these assembled at another branch because of the limitation of the size of the dispensary. But, the record for one patient seen did not document past changes in dose or other issues. This denied the checking pharmacist a clear clinical history of the patient.

The pharmacist seen said that he routinely counselled patients prescribed high risk drugs such as warfarin and lithium. INR levels were recorded. He was seen to counsel most acute 'walk-in' patients. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. A text service was offered whereby a message was sent to patients letting them know that their prescriptions or items that were owed to them were ready to collect. The staff seen were aware of the new sodium valproate guidelines.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist on the PIFs. Signatures were obtained indicating the safe delivery of all medicines and

owing slips were used for any items owed to patients. Suitable patients were encouraged to use the company's managed repeat prescription service so that all regular prescribed items ran in line to reduce wastage, to optimise the use of medicines and to identify any non-adherence issues. Patients were asked to check, when they collected their medicines, if they still needed everything that they had ordered the previous month. Any patients not wanting an item were routinely referred to the pharmacist. Potential non-adherence issues were not always identified at the labelling or ordering stage, but they were at the hand-out stage.

Medicines and medical devices were obtained from Alliance Healthcare and AAH. Specials were obtained through Alliance Specials. Invoices for all these suppliers were available. A scanner was used to check for falsified medicines as required by the Falsified Medicines Directive (FMD). This was aligned to the labelling process and so reduced the risk of picking errors. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There was one patient-returned and some out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was no separate bin for cytotoxic and cytostatic substances but there was a list of such substances that should be treated as hazardous for waste purposes. The staff said that they would separate any such substances. The waste medicine bins could be better sited.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 17 October 2019 about ranitidine effervescent tablets. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the appropriate equipment and facilities for the services it provides. And, the team members make sure that the equipment is clean.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (5 - 250ml). There were three tablet-counting triangles, one of which was kept specifically for cytotoxic substances and two capsule counters. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet including access to Medicines Complete.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computer was password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and it was said that conversations in a normal voice could not be overheard (but see under principle 3 with regard to the door).

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.