General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 55 Henleaze Road, Henleaze, BRISTOL, Avon, BS9 4JT

Pharmacy reference: 1028663

Type of pharmacy: Community

Date of inspection: 05/08/2019

Pharmacy context

This is a community pharmacy in a residential area on the outskirts of the city of Bristol. There are a few local shops in the area. Most people using the pharmacy are elderly. The pharmacy dispenses NHS prescriptions and private prescriptions and sells over-the counter medicines. They supply medicines in multi-compartment devices to help vulnerable people in their own homes to take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy team do not identify and manage all risks. They are behind with their workload and this increases the risks of mistakes. The pharmacy is short-staffed and there is evidence to support that this contributed to a recent error involving a child.
		1.4	Standard not met	The pharmacy asks customers for their views but recent feedback on the length of time it takes for customers to be served has not been addressed.
2. Staff	Standards not all met	2.1	Standard not met	There is evidence to support that there are not always enough staff for the pharmacy to operate safely and effectively.
		2.5	Standard not met	There is poor communication and the pharmacy team do not feel supported by their managers. There is evidence that no action has been taken when individuals of the pharmacy team have raised legitimate concerns.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	There is evidence that some pharmacy services are provided in a way that could put people's safety at risk.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team do not identify and manage all risks. They are behind with their workload and this increases the risks of mistakes. The pharmacy is short-staffed and there is evidence to support that this contributed to a recent error. The pharmacy asks customers for their views but recent feedback on the length of time it takes for customers to be served has not been addressed. The pharmacy team generally keep people's private information safe. But, the design of the front bench and the lack of a clear queuing system for customers, increases the chance of a breach in confidentiality. The pharmacy is appropriately insured to protect people if things go wrong.

Inspector's evidence

The pharmacy team did not manage and identify all risks. At the time of the inspection they were behind with their workload. The dispensing benches in the downstairs dispensary were cluttered. Many baskets, waiting to be checked were stored on top of one another. This increased the risk of errors. There were several empty shelves. The staff said that this was because they were getting prepared for the introduction of the 'Columbus' system. They moved the baskets to these empty shelves during the visit. The pharmacist reported that she was behind with the checking of prescriptions because of staff shortages (see further under principle 2). The inspector telephoned the area manager who sent additional pharmacist cover so that this backlog of work could be cleared.

In addition to the staffing issues mentioned above, the inspector observed a potential patient safety issue with a dosette tray (see further under principle 4). Mirtazapine had been placed in the tray, without a valid prescription and there was no label on the tray that it was included.

Dispensing errors and incidents were recorded. The last error at the pharmacy had been on 23 July 2019. Two errors had been made involving a child. Ranitidine liquid had been incorrectly labelled, from the patient's prescription medication record, also previously incorrect, and, Novomix Flexpen, had been given instead of cartridges. The pharmacist said that she believed that a major contributing factor to this error was staffing levels. As a result of the error and the staff pressures, she had asked to step down as manager of the store.

Near misses were recorded. The log was reviewed by the pre-registration student but she had recently left and there were no plans for her to be replaced. Before she left, she had identified several mistakes with rivaroxaban and rosuvastatin. Because of these, the dispensing staff had been instructed to use the company's accuracy checking tool before passing the prescription to the pharmacist for checking. The risk of picking errors with 'look alike, sound alike' (LASA) drugs was identified such as propranolol and prednisolone. The Superintendent's Office had sent a laminated sheet containing LASA drugs, such as, quinine, quetiapine, atenolol, allopurinol, amlodipine and amitriptyline. These were displayed on the computer monitors with instructions that these should be highlighted on the 'Pharmacist information Forms' (PIFs) that were attached to all prescriptions, according to company procedures. However, most of the PIFs seen did not include any useful information. They mainly stated that the patient was due for a medicine review or was signed up to the company's text message service. This meant therefore that some important issues may not have been highlighted to the pharmacist.

The main dispensary was limited in size for the workload and as mentioned above, extremely cluttered at the beginning of the inspection due to a backlog of work. There were two work stations on the front

bench which were open in design. The staff reported that only acute prescriptions, with one to two items were dispensed here, because of the possible accidental disclosure of confidential information. But, there was no clear queuing system and people were seen to be waiting at both stations, in close proximity of each other. An assembled prescription for a patient was clearly visible to the customers waiting to be served. Because of the staffing issues, each station was not manned, thus increasing the risk of a breach of confidentiality. Upstairs, there was a separate spacious room which was used for all the monitored dosage system services. This was large, tidy and organised. But, there was a backlog of dosettes that needed to be checked.

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. A dispenser was seen to refer a patient, who had bought some chloramphenicol eye drops for conjunctivitis a month previously, but, the condition had not resolved, to the pharmacist. Another dispenser said that she would refer all requests for customers on prescribed medicines to the pharmacist.

The pharmacy had a complaints procedure. The staff 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. The store manager looked at this feedback regularly. An annual pharmacy specific customer satisfaction survey was also done. In the 2018/2019 survey, 82% of customers who completed the questionnaire rated the pharmacy as excellent or very good overall. But, 7.5% of customers complained about the queuing times. At the time of the visit, the inspector saw long queues. One customer said that she had been waiting 15 minutes to be served. She had gone to the store on the previous Saturday, but the queue was so long that she decided to go back on the day of the inspection.

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 and fridge temperature records were in order. The specials records were not stored tidily and several were seen to have no patient details. The pharmacy was six weeks behind with their date-checking procedures.

There was an information governance procedure and 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 completed the company's e-Learning module on the safeguarding of both children and vulnerable adults. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE). Local telephone numbers were available to escalate any concerns relating to both children and adults. The staff had completed 'Dementia Friends' training.

Principle 2 - Staffing **Standards not all met**

Summary findings

There is evidence to support that there are not always enough staff for the pharmacy to operate safely and effectively. Team members who leave are not promptly replaced and this puts pressure on the remaining members. There is inadequate provision to cover both planned and unplanned absences. Overall, there is poor communication and the pharmacy team do not feel supported by their managers. There is evidence that no action has been taken when individuals of the pharmacy team have raised legitimate concerns.

Inspector's evidence

The pharmacy was in a residential area on the outskirts of the city of Bristol. They dispensed approximately 10,000 NHS prescription items each month with the majority of these being repeats. 170 domiciliary received their medicines in monitored dosage systems (MDS). Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager, with a second pharmacist on three days one week and four days the alternate week, three full-time NVQ2 trained dispensers, two part-time trained dispensers, one full-time counter assistant (only just appointed with no medicine knowledge and in her probationary period) and one part-time trained medicine counter assistant. A trained medicine counter assistant left the store in February 2019, but, because of the re-structuring of the business, the post was not advertised until April 2019. It had now been filled but the person had only been in post for one day. The store used to have a pre-registration student but she had left the Wednesday before the visit. In the recent past the store had an accuracy checking technician.

The pharmacist said that the pharmacy was largely coping with these staffing levels, until the beginning of July 2019. On 12 July 2019, the pharmacy was about ten days behind with their workload. A pre-registration student was sent to help from another store. The student covered the medicine counter which allowed the trained dispenser, who had been covering the counter, to resume duties in the dispensary. One dispenser was mainly responsible for the assembly of the domiciliary trays. The pharmacy had recently taken on the trays from their branch in Broadmead. This had resulted in an increase in trays from 140 to 170. Just 15 hours extra dispensary cover had been secured to cover the extra workload. The dispenser said that she had raised the staffing levels with the manager. She was also due to go on holiday the week after the visit and so she was trying to get ahead of the workload. She did not know if any extra staff had been secured to cover her holiday.

As mentioned under principle 1, the inspector secured extra pharmacist help on the day of the visit because the pharmacy was behind with their workload. The pharmacy normally had extra pharmacist cover over the lunch period to allow the pharmacist manager to have a lunch break. In the week of the visit, the lunch relief pharmacist was on holiday. No replacement had been sent and the dispensary had to close for the week. On the Saturday before the visit, there were only two dispensers, one whom was working just half the day. Two pharmacists had been employed to address this shortage. One did the assembly of medicines and the other did the checking.

The staff said that they managed to complete the compulsory staff training but had not done any 30 minutes tutors for a long time because of the staffing issues. Some reported that they did not feel supported by their immediate manager or by staff higher up in the company. The manager and a

dispenser said that on one Saturday recently, there was only the pharmacist and two members of staff on duty. The manager said that she had been promised help but they did not turn up. Overall, there was clearly an issue with poor communication. No staff meetings were held and there were no staff huddles.

Principle 3 - Premises ✔ Standards met

Summary findings

Generally the pharmacy provides an appropriate and professional environment for the services it provides. There is good signposting to the consultation room so it is clear to people that there is somewhere private to talk. But, there is no heating or air conditioning in this room and so people may not be comfortable in here.

Inspector's evidence

The downstairs dispensary was cluttered on the day of the visit. Many baskets, waiting to be checked were stored on top of one another. This posed a risk of errors and did not present a professional pharmacy image. During the inspection, these baskets were moved to empty shelves which gave clearer bench space. The upstairs dispensary was organised and tidy. The premises were clean and well maintained.

The consultation room well signposted but situated at the front of the pharmacy. There was a large clear glass panel which backed onto the pavement. This was obscured with a blind. But, the situation of the room, together with the large glass panel and the fact that it had no heating or air-conditioning, meant that it was very warm in the summer and very cold in the winter. This would potentially make it uncomfortable for patients. The door to the consultation room also contained a clear glass panel, but this too had a blind. The room did have a computer and a sink. It was quite small but the door opened outwards and so access by the emergency services would not be impeded if a patient had to be placed in the recovery position on the floor. Conversations in the consultation room could not be overheard. The computer screens were 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 in the main areas of the pharmacy, but not in the consultation room. The temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Many items for sale were healthcare related but several other items were also sold.

Principle 4 - Services **Standards not all met**

Summary findings

The services that the pharmacy offers are accessible to all people. But, there is evidence that some pharmacy services are provided in a way that could put people's safety at risk. And, there is inadequate professional intervention, in a timely manner, to act on some potential patient safety issues. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The pharmacy has arrangements in place to deal with any concerns about medicines or medical devices.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with a push-button opening front door. The store had a translation application on their iPad for non-English speakers. The pharmacy could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicine Use Reviews (MURs), New Medicine Service Reviews (NMS), sexual health, c-card scheme, supervised consumption of methadone and buprenorphine and seasonal 'flu vaccinations. The latter was offered under a private agreement as were vaccinations against pneumonia. Malaria prophylaxis was provided against private prescriptions according to a company scheme.

The pharmacists had completed suitable training for the provision of seasonal 'flu vaccinations and sexual health services including face to face training on injection technique, needle stick injuries and anaphylaxis. The had also completed the Gateway training on the prophylaxis of malaria and consulted the 'fit for travel' website for such customers.

The pharmacy was busy and 170 domiciliary patients received their medicines in multi-compartment trays. The number of dosette patients had recently increased from 140 patients. The prescriptions were assembled in a separate spacious room upstairs. But, one NVQ2 qualified dispenser was mainly responsible for these. The trays were assembled on a four-week rolling basis. There was a clear progress log of the entire process. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. The company procedures for the domiciliary trays required that, following any changes, a new sheet was to be completed. The old sheets were kept, but potentially the poly-pockets could become overly full. In addition, there was no clear concise chronological audit trail of changes or issues. This denied the checking pharmacist easy reference to the past clinical history or any other issues with the patient.

On the day of the visit, Monday 5 August 2019, a customer came to collect a dosette tray for her mother. She had gone to the pharmacy on the previous Saturday, 3 August 2019, but, because the queue was so long she decided to go back on the Monday. The dosette should have been ready on Friday 2 August 2019. She waited 15 minutes to be served. A dispenser went upstairs to locate the trays. She came back with four trays that had not yet been checked. A post-it note was placed on the trays that the pharmacy was waiting for a prescription for mirtazapine. But, the mirtazapine had been assembled into the trays. And, a label to that effect, had not been included. There was therefore no audit trail of the person who had placed the mirtazapine in the tray with no valid prescription in place. The staff said that the prescription had been requested on 30 July 2019. It was not clear why this had not been chased up before since the trays were due on 2 August 2019. Moreover, no one had telephoned the patient's doctor. This only happened after prompting by the inspector that this might

be sensible to ensure that the item had not been stopped. This scenario posed a significant potential risk to patient safety and also demonstrated poor prescription ordering management and the lack of appropriate and timely professional interventions.

Medicines and medical devices were obtained from Alliance Healthcare, AAH and Boots Head Office. Specials were obtained from Alliance Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. There was one patient-returned CD which was appropriately labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Other stock was stored tidily on the shelves. The staff were aware of the Falsified Medicines Directive but there were no scanners to check the medicines. Date checking procedures were in place with signatures recording who had undertaken the task, but as mentioned under principle 1, due to staffing issues these were six weeks behind schedule. Bins for waste medicines were available for waste and used. There was dedicated bin for cytotoxic and cytostatic medicine waste together with a list of the substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts 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 30 July 2019 about aripiprazole 1mg/ml solution. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 -250ml). There were several tablet-counting triangles and two capsule counters. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2018 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were 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 was information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.