General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1 School Road, Park Estate, Cadbury Heath; Warmley;, BRISTOL, Avon, BS30 8EN

Pharmacy reference: 1028730

Type of pharmacy: Community

Date of inspection: 09/05/2019

Pharmacy context

This is a community pharmacy in a residential area to the east of the city of Bristol. Its customers are mainly elderly but, there is a school close by and so some parents also use the pharmacy. They mainly dispense NHS prescriptions and sell 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 team members identify and manage risks satisfactorily. But, they could learn more from their mistakes to prevent them from happening again. The pharmacy identifies prescriptions for high-risk medicines. This helps its staff to supply these safely and to make sure that people use them properly. The pharmacy is appropriately insured to protect people if things go wrong. The team keep the up-to-date records that they must keep by law. They keep people's private information safe and know how to protect vulnerable people.

Inspector's evidence

The pharmacy staff identified and managed most risks. But, there had been a recent hand-out error and no specific actions to reduce the likelihood of a recurrence, such as, initialling the post-code to demonstrate that this had been thoroughly checked, had been put in place. Few near miss mistakes were recorded. The regular pharmacist said that she tried to record all mistakes but that locums often did not. She said that they did identify some things to reduce the likelihood of picking errors, such as highlighting any prescriptions for ramipril tablets. There was a patient safety review which was reviewed monthly and looked at tasks, the workplace, the team and people. Review of the near miss log was part of the overall monthly review. The pharmacy team said that they were supported to learn from any mistakes. Select with care labels were seen on several shelf-edges as part of the company's 'Safer 6' campaign such as amlodipine and amitriptyline. The risk of picking errors with 'look alike and sound alike' drugs was identified such as propranolol and prednisolone. The superintendent's office had recently sent a laminated sheet containing six drugs, quinine, quetiapine, atenolol, allopurinol, amlodipine and amitriptyline. This was displayed near the computer monitors with instructions that these should be highlighted on the 'pharmacist information forms' (PIFs) that were attached to all prescriptions. High-risk items such as the sulphonylureas and quetiapine were clearly separated. The superintendent's office also sent monthly governance bulletins.

The dispensary was divided into two areas. There was a front 'walk-in' area and a back area for prescriptions sent by the surgery, mainly repeats. Both had clear labelling and assembly areas. There was one checking bench in the front area. Shelves above this were used for prescriptions waiting to be checked to keep the checking bench clear. There was a dedicated hatch for the substance misuse patients. The pharmacy did not assemble any medicines into monitored dosage systems.

Coloured cards were used which highlighted, amongst others, patients who were waiting, those calling back and prescriptions containing fridge items, warfarin, methotrexate and controlled drugs. All assembled prescriptions examined had a completed PIF where any relevant information was recorded. High-risk drugs and high-risk patients were identified and appropriately counselled.

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. In addition, all prescriptions contained a four way stamp which included the initials of who had done the clinical check, the dispensing, the accuracy check and

the hand-out. Regular audits were undertaken by the area manager and clinical governance pharmacists. Risk assessments were performed such as one in September 2018 prior to the seasonal flu vaccination service being offered.

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 clearly set out in the SOPs and the staff were clear about their roles. A care card for medicines sales specific to the store was displayed close to the medicine counter. This was not signed or dated and included no local additions. Care cards 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 her. 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 were clear about the complaints procedure and said that feedback on all concerns was actively 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 each day. An annual pharmacy specific customer satisfaction survey was also done. 95% of customers who completed the latest questionnaire rated the pharmacy as excellent or very good overall. But, 3% of customers had given feedback about having somewhere private to talk. The consultation room was well signposted on the door but the room was situated around a corner and not visible when people entered the store. The area manager said that she would investigate better signposting to this.

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 pharmacy team 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. Sensitive telephone calls were taken in the consultation room or out of earshot. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff had a good understanding of safeguarding issues and had completed the company's e-Learning module on the safeguarding of both children and vulnerable adults. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education (CPPE). 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 sufficient staff to deal with the workload and the team is supported by the company when someone is unexpectedly absent. The team are encouraged to keep their skills up to date. The team members who are in training are supported. The pharmacy team work well together. They are comfortable about providing feedback to their manager and this is acted on.

Inspector's evidence

The pharmacy was a in residential area to the east of the city of Bristol. They dispensed approximately 4,500 NHS prescription items each month with the majority of these being repeats. No medicines were assembled into multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager, with extra pharmacist cover for half a day each week, one full-time NVQ2 trained dispenser and one part-time NVQ2 trained dispenser who was a NVQ3 trainee technician. The store had a vacancy for a full-time trained or trainee dispenser.

The part-time dispenser was flexible and generally covered any unplanned absences. Extra help was available from other stores or from the relief team, if necessary. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix. The extra pharmacist cover for half a day a week allowed the manager to do her managerial tasks.

The staff were well qualified and clearly worked well together as a team. Even though the pharmacy was one member short, they were not behind with their workload. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. The part-time dispenser had raised that she would like to do the technician training. Because of this, she had been enrolled on the course.

The staff were encouraged with learning and development and completed e-Learning and 30 minute tutors. The pharmacist said that because they were short of one member of staff, her team had not completed the 30 minute tutors in the last few months. She said that any compulsory e-Learning was completed in work-time. The trainee technician was allocated learning time, one day every few months. There was no dedicated training rota for this. The pharmacist said that she would investigate setting up a dedicated rota. She reported that all learning was documented on her continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. There were daily staff ‘huddles’ and a more formal monthly staff meeting. All the staff were aware of the company’s whistleblowing policy.

The pharmacist reported that she was set overall targets, such as 400 annual Medicines Use Reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. It is tidy and organised. There is good signposting to the consultation room on the door. But, this is not visible to people entering the pharmacy and so they may not know that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and generally well maintained. The front door to the pharmacy was seen not to close properly.

The consultation room was spacious and well signposted on the door. But, the signage was not visible to customers when they entered the store. The room contained a contained a computer and a sink. There was only a small heater in here and on the day of the inspection it felt cold. The pharmacist said that during the winter she put the heater on at the beginning of the day to ensure it was comfortable for customers. 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 and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

Most people can access the services the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The services are generally effectively managed to make sure that they are provided safely. The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. And, the pharmacist intervenes if people are not using their medicines properly, they are suffering from side effects or medicines are not safe for them to take. But, the team could be better at identifying any concerns with people who use the pharmacy's managed repeat prescription service. The pharmacy gets its medicines from suppliers. Medicines are stored and disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was no independent wheelchair access to the pharmacy and the consultation room because of a step up to the pharmacy. There was a bell, but this was not prominently signposted. 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 Medicines Use Reviews (MURs), New Medicine Service (NMS), supervised consumption of substance misuse treatment services, needle exchange and seasonal flu vaccinations. The latter was also provided under a private agreement.

The 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.

Substance misuse patients had their medicines supervised. There was a dedicated folder for these patients and any issues were recorded on the patient's electronic prescription medication record. A dedicated hatch was used to serve these patients. They were not routinely offered water or engaged in conversation to reduce the likelihood of diversion which was against the local shared care guidelines, The Recovery Orientated Alcohol and Drugs Service (ROADS), guidelines. The pharmacist was not aware of these and the inspector sent her a copy.

No medicines were assembled into multi-compartment compliance aids. There was a good audit trail for all items dispensed by the pharmacy, but any items ordered on behalf of patients using Webscript only documented the number of items ordered and not the exact details. Interventions were seen to be recorded on the patient's prescription medication record. The pharmacist routinely counselled patients prescribed high risk drugs such as warfarin and lithium. INR levels were recorded. She 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 were aware of the new sodium valproate guidelines. They had two people in the sat risk group who may become pregnant and these were given information cards with each prescription.

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. However, patients were not 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 not routinely referred to the pharmacist.

The pharmacist reported that she frequently identified during MURs that patients did not use their inhalers correctly. They also did not take their levothyroxine 20 minutes before food and with just water. The pharmacist was a qualified independent prescriber with a hypertension speciality. She identified side effects, such as patients taking all their hypertensive medicines in the morning resulting in the patient being dizzy because of the sudden drop in blood pressure. These patients were referred to their doctors and the dosage regime was altered. The pharmacist had also picked up a potential serious issue during a NMS review where a patient had been prescribed both lercanidipine and amlodipine. She contacted the doctor and the amlodipine was stopped.

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 were two patient-returned CDs and one out-of-date CD. 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 had not received any training on the Falsified Medicines Directive and did not have any scanners to check for falsified medicines. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins for storing waste medicines were available for waste and used and there was a cytotoxic bin and a list of 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 29 April 2019 about prednisolone 5mg tablets. 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 to 500ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was access to the internet and to Medicines Complete.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. Designated bins for storing waste medicines were available and used and there was adequate storage for all other medicines.

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.