General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 17-19 Broad Street, MARCH, Cambridgeshire, PE15 8TP

Pharmacy reference: 1029294

Type of pharmacy: Community

Date of inspection: 21/11/2019

Pharmacy context

This community pharmacy is on a busy high street in the centre of the town. It offers the usual range of pharmacy services including dispensing NHS and private prescriptions and selling medicines to people over the counter. It provides Medicines Use Reviews (MURs) and New Medicine Service (NMS) checks. It administers seasonal flu vaccinations under both private and NHS patient group directions (PGDs). Some people are provided their medicines in multi-compartment compliance packs to help them manage their medicines. The pharmacy operates a needle exchange scheme. And some people receive medicines as part of a substance misuse service. The pharmacy delivers some prescriptions to people.

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	Good practice	2.2	Good practice	The pharmacy's team members receive good support to make sure they have the right skills and knowledge for their roles.
		2.5	Good practice	The team members share ideas about how to make the pharmacy's services safer and these suggestions are implemented wherever possible.
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

Overall, the pharmacy identifies and manages the risks associated with its services well. Its team members understand their roles and work within these. The pharmacy makes the records it needs to by law and these are largely accurate. The team members keep people's personal information safe. And they understand their role in making sure vulnerable people are protected. They learn from their mistakes and make improvements to prevent similar events happening again. But the reasons why some mistakes are happening isn't recorded so the pharmacy may be missing opportunities to learn and improve from these.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) which were issued by head office and reviewed regularly. There was evidence that most staff had read and signed SOPs relevant to their roles. But the record had not been completed by a trainee pharmacy advisor who had worked at the pharmacy for over five months.

To reduce risks when dispensing, baskets were used to keep people's prescriptions separate. The pharmacists used a designated area of dispensary to complete their final accuracy check. This area was kept clear of other items to reduce distractions. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to produce an audit trail. The recently introduced medication record system had enhanced the safety checks during the dispensing process, meaning that the likelihood of selecting the wrong medicine had been greatly reduced.

The pharmacy team used written notes to highlight key messages to the pharmacist. Most but not all dispensed prescriptions had these; the SOP said they should be used in all cases. The notes were used to communicate clinical information and eligibility for certain services. The pharmacy also had laminated cards to highlight higher-risk medicines. These cards included prompts about questions to ask people when they collected their medicines. Team members said that they would escalate any queries to the pharmacist.

Mistakes which reached people were recorded and reported to head office. There was a process to review these to understand how the incident had happened and to put in place improvement actions to prevent the same thing from happening.

Mistakes made during the dispensing process which were corrected before being handed out, known as near misses, were recorded. Records of near misses viewed did not include any information about why a mistake had been made or other contributing factors. But they were clear about the type of mistake; dispensing the wrong quantity was now one of the most common mistakes. This had been highlighted to the team. The team members were also making use of stickers to highlight medicines with similar names or packaging to reduce selection errors. 'Select and speak it' stickers had been applied where items such as atenolol, amitriptyline, carbimazole and carbamazepine where stored to raise awareness when selecting medicines. Dispensing errors and near misses were reviewed each month to identify any patterns and trends. Theses reviews were recorded, and the outcomes and next steps were shared with

the team each month as part of a patient safety review process. Mistakes that occurred at other branches were also shared with the team to prevent similar happening again. A recent error which had resulted in a prescription being handed out to the wrong person had been shared with the team members and to remind them to follow the right processes.

Staff had a clear understanding of what they could and couldn't do if there was no pharmacist present. The roles and responsibilities of staff were included in the SOPs. And job titles were included on staff name badges to help people know who they were talking to. The team members were asking the necessary questions when handing out prescriptions and referred queries to the pharmacist throughout the visit.

The pharmacy had the appropriate insurances in place for its services. It asked customers for their views about its services through an annual survey. Responses to a survey from 2017 and 2018 were displayed in the shop but not for the most recent one conducted. The pharmacy provided information to people about how they could raise concerns or complaints in one of the leaflets it displayed and on the back of till receipts.

The wrong details about the current responsible pharmacist (RP) were displayed at the start of the inspection; this was changed immediately. The record for the RP was complete. Controlled drug (CD) registers were available and entries were up to date. Running balances were kept and were checked regularly though amendments to these when discrepancies were found were not always clear or accurate. This was discussed with the RP and advice given about how best to deal with discrepancies. CDs returned by people for disposal were recorded on receipt. Electronic private prescription records did not always include all the correct information. An assurance was given that this would be monitored.

The pharmacy had policies to protect people's information and staff received regular training on this topic. Computer screens carrying people's information could not be viewed by the public. Confidential waste was separated from other waste and disposed of securely. The electronic patient medication record system was password protected and people used their own NHS smartcards to access electronic prescriptions and summary care records. Staff used the consultation room for more sensitive conversations with people.

To protect more vulnerable people, the pharmacy team members had read and signed procedures about safeguarding and this training was refreshed regularly. As part of the requirements for some of the additional services offered, the RP had completed level 2 safeguarding training. Information about safeguarding support agencies was available to staff in the event they had a concern.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough, suitably trained staff to provide its services safely. Its team members are given good support to help keep their skills and knowledge up to date. They also have opportunities to develop their pharmacy and management careers. They share and can implement ideas to make the pharmacy safer and more efficient. And they learn from mistakes in an open and honest way. The team members have appropriate support in place should they need to raise any concerns about the pharmacy.

Inspector's evidence

All members of the pharmacy team had either completed or were currently undertaking the right accredited training for the roles they undertook. Team members were given opportunities to progress their careers in both management and pharmacy professions. The deputy manager had recently transferred from another store where she had been a pharmacy technician and was now hoping to become an accuracy checking technician. Two members of staff were currently training to become pharmacy technicians. The rest of the team comprised two trainee pharmacy advisors, and three trained pharmacy advisors. A further member of staff was trained to work on the medicines counter, and the branch manager was also a trained pharmacy advisor so could assist in the dispensary when needed. The team coped with the workload during the inspection and worked closely together. The responsible pharmacist during the inspection worked at this branch full-time. She received extra pharmacist support on Fridays to help with some of the prescription checking workload.

Staff members were trained to complete a variety of tasks in the dispensary, including the dispensing of multi-compartment compliance packs. This meant there was continuity of service in the event of staff absence. Staff were observed referring queries to the pharmacist where appropriate. When asked, they knew which tasks could not be completed if the pharmacist was absent.

There appeared to be good communication amongst the staff. Staff held huddles or shared information through one-to-one meetings with their managers and each other. Managers also had a conference call each week with other pharmacies in the same company to share information about operations and services. There were good handover arrangements in place, so tasks could be completed promptly, and queries resolved. And staff were encouraged to share ideas to improve how the pharmacy operated. The deputy manager explained how she had introduced notice boards in staff areas to improve handovers and highlight key messages amongst the team. This had been particularly helpful in improving communication about the compliance pack service including changes in people’s medicines. She had also reorganised the area used for preparing compliance packs which had reduced clutter, improved inventory management, and had created a safer space for this activity.

Ongoing training was available to the team and there was evidence this was completed regularly, helping staff members to keep their skills and knowledge up to date. This included reading updated SOPs and training modules on an e-learning platform. Some training was mandatory by the company and this was monitored to make sure it was completed. Staff were provided with some training time at work.

The pharmacy's team members said that they did not feel undue pressure to achieve targets. They said they felt able to raise any concerns if needed and the company had a whistleblowing policy. There was a confidential helpline for staff if they wanted to talk to someone outside of the store. Formal appraisals were completed regularly with team members to provide feedback about how they were doing and identify any areas needing further support.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are suitable for the services it offers, and they are adequately maintained. The pharmacy has a consultation room which offers people more privacy for services and sensitive conversations.

Inspector's evidence

The pharmacy was reasonably clean and tidy throughout and could be protected against unauthorised access. Fire doors were kept free of obstructions. The paintwork in some non-public facing areas was somewhat marked and the floor, in places, needed sweeping. Except for medicines supplied in multi-compartment compliance packs, prescriptions were dispensed at terminals behind the counter. Additional screening had been created at these locations to prevent private information being seen from the shop floor. The pharmacist accuracy checked these prescriptions away from the counter in a quieter area of the dispensary to reduce risks.

Space in the parts of the dispensary close to the medicines counter was very limited. However, the dispensing workbenches were kept as clear as possible to reduce risks when dispensing. There was a separate area to the rear of the dispensary used for preparing multi-compartment compliance packs; this area was large enough for the workload and meant that distractions during the dispensing process were reduced.

There was adequate heating and lighting throughout the pharmacy and air-conditioning to control the room temperature. A problem with the store heating was rectified during the inspection. The pharmacy had hot and cold running water available.

There was seating near the medicines counter for people waiting for services. The pharmacy had a consultation room which was suitable for private consultations and conversations. There was no confidential information displayed in this room and a chaperone policy for the use of this room was displayed. Posters about dealing with needlestick injuries, anaphylaxis and fainting were also displayed, as part of the vaccination service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works together in an organised way to make sure the pharmacy's services are safe and are generally accessible to people. Members of the pharmacy team know about the checks they should make when supplying medicines which are higher-risk so people get the right advice about their medicines. But information about blood tests is not always recorded which makes it harder for the pharmacy to demonstrate these checks are always made. The team checks its medicines regularly to make sure they are in-date. It could do more to make sure medicines which are no longer suitable for dispensing are removed from its shelves.

Inspector's evidence

The layout of the pharmacy and step-free access meant it was wheelchair accessible. However, the entrance doors with automatic opening had been disabled making it more difficult for people with mobility problems. The pharmacy's opening hours were clearly displayed. Leaflets and notices in the retail area provided information about the pharmacy and its services.

A notice board in the shop was reserved for information about healthy living; the current display was about winter health. The pharmacy could also provide evidence of what they had done to promote previous campaigns including mental health. Staff said that more people had wanted help to give up smoking when the pharmacy ran its stop smoking campaign; these people had been referred to the pharmacy's stop smoking service. The pharmacist could offer the Community Pharmacist Consultation Service (CPCS), and people used this mainly at weekends when GP practices were closed. The pharmacy also signposted people to other sources of support when needed.

Some people who needed help managing their medicines were provided with multi-compartment compliance packs. There was a new SOP to support this service so the pharmacy could assess people's needs appropriately; in practice, this was done by the surgery. This service was well-organised, with enough lead time to make sure the packs could be prepared safely and supplied on time. The pharmacy kept records about medicines, changes to medicines and administration times, hospital admissions and discharge notes. Assembled packs included descriptions which allowed individual medicines to be identified. Patient information leaflets were supplied to people every four weeks. For those people receiving warfarin, there was a process to contact the person to check their current INR and dosage before sending out the medicine; warfarin was not included in compliance packs.

The pharmacy delivered some people's medicines. It kept records about deliveries which included recipient signatures. This helped it show that the medicines had been delivered safely.

The pharmacy highlighted prescriptions for higher-risk medicines so checks could be made, and advice provided when these were handed out. The team members sometimes recorded relevant blood test results when people were supplied with warfarin; one person's records, checked at random, showed this did not always happen. The pharmacy's team members were aware about pregnancy prevention advice to be given to people in the at-risk group when they were supplied with sodium valproate. The team members couldn't locate the relevant educational materials or safety stickers to apply to

dispensed medicines and said they would re-order them straightaway.

Pharmacy-only medicines were stored so they couldn't be self-selected by customers. Stock requiring cold storage was stored in two fridges. The pharmacy kept temperature records to make sure fridges stayed at the right temperature. However, on two occasions in the previous month, the temperature recorded was slightly above the recommended range and there was no evidence to show what the pharmacy had done about this. The pharmacist said they would keep a record of follow-up action in future. There was no ice build-up in the fridges. The pharmacy stored CDs appropriately. Expired CDs were separated from other stock and there were denaturing kits available for their safe disposal.

Medicines were obtained from licensed wholesalers or specials manufacturers. Medicines were stored in appropriately labelled containers. The pharmacy regularly checked its medicines' expiry dates. It kept records about completed checks and highlighted medicines if they were approaching their expiry dates. When some medicines were spot-checked, a small number were out of date, but they had been highlighted, reducing the risk of supply. The date of opening was added to liquid medicines so dispensers could assess if these were fit for purpose in the future. Most expired and returned medicines were segregated and placed in pharmaceutical waste bins. The medicines waste bins were kept safely away from other medicines.

Stock inventories were monitored to try to reduce prescriptions that could not be supplied in full. Some medicines, including hormone therapy treatments, were in short-supply. The staff explained how they were working with local surgeries to try to make sure people's care was not adversely impacted by these shortages. The new dispensary computer system also helped staff identify stock held in local branches to fulfil prescriptions.

The pharmacy had not yet made any adjustments in line with the Falsified Medicines Directive. The pharmacy was changing its dispensing equipment to meet the requirements. The pharmacy received messages from its head office about medicine recalls. It kept records about the actions it had taken. For example, recent alerts about ranitidine products had been received, stock had been checked, and an audit trail kept showing what the pharmacy had done about these.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities to provide its services safely, and it maintains them properly.

Inspector's evidence

The pharmacy had crown-stamped measures available in the dispensary to accurately measure liquids and these were clean. Some were reserved for specific medicines to prevent cross-contamination. Equipment for counting tablets was also available and was clean. The pharmacy had up-to-date reference sources available on paper and on the internet. Electrical equipment had been safety tested in January 2019. Fire alarms were also tested regularly. The staff knew how to report maintenance issues, and these were acted on; there had recently been a problem with the boiler and a heating engineer was on site during the inspection.

The pharmacy was equipped with an induction hearing loop. Confidential information could not be seen by people using the pharmacy. Computers were password protected to prevent unauthorised access to people's medication records. And the pharmacy had cordless phones, so staff could hold phone calls out of earshot of the public.

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.