General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2 Serpentine Green Shopping Centre, The Serpentine, Hampton Harcourt, PETERBOROUGH, Cambridgeshire, PE7 8BD

Pharmacy reference: 1029344

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This community pharmacy is located within a large store in a busy shopping centre on the outskirts of Peterborough. It dispenses NHS and private prescriptions and sells medicines over the counter. The pharmacy also provides a prescription delivery service, a needle exchange service, the Community Pharmacist Consultation Service (CPCS), and emergency hormonal contraception. Some people are supplied their medicines in multi-compartment compliance packs to help them manage their medicines better. The pharmacists administer flu vaccinations under private and NHS patient group directions (PGDs). And the pharmacy can also provide pneumonia vaccinations and hair retention treatments under PGDs. Some people receive medicines as part of a substance misuse service. Over half of the pharmacy's prescriptions are dispensed at an off-site hub.

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	2.1	Good practice	The pharmacy reviews its staffing needs when new services are planned and increases the cover available so it can deliver these services effectively.
		2.2	Good practice	The pharmacy provides good support to help keep its team members' skills and knowledge up to date and to develop their careers in pharmacy.
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. New services are risk-assessed in advance so they can be introduced safely. The pharmacy's team members understand their roles and work within these. They generally follow the company's procedures. 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 staff had read and signed SOPs relevant to their roles. A task matrix showing which members of staff could complete various tasks had been filled in. Staff were observed referring queries to the pharmacist throughout the inspection. They had a clear understanding of what they could and couldn't do if there was no pharmacist present.

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. Instalment doses were largely made up in advance at quieter times to reduce mistakes. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to produce an audit trail. 'Select and speak it' stickers had been applied where items such as atenolol, amitriptyline, carbimazole and carbamazepine were stored. This was to remind staff to be particularly careful when selecting these medicines as they sounded or looked like each other and errors involving these had occurred elsewhere. Other learning points from incidents which had occurred elsewhere were also highlighted in a company newsletter.

The pharmacy team used written notes referred to as 'pharmacist information forms' or 'PIFs' 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 pharmacy also had laminated cards to highlight higher-risk medicines. These cards included prompts about questions to ask people when they collected their medicines. The company provided stickers to flag prescriptions for controlled drugs and to clearly show the expiry date of the prescription. On a small sample checked, the stickers had not been used but the item on the prescription form had been highlighted so staff could still make the appropriate checks.

Some of the mistakes made during the dispensing process which were corrected before being handed out, known as near misses, were recorded. Three had been recorded so far in December. The recently introduced medication record system had enhanced the safety checks during the dispensing process. Team members reported that they now had fewer mistakes where the wrong medicine was dispensed. Most of the near miss records viewed did not include any information about why a mistake had been made or other contributing factors.

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.

Dispensing incidents were reviewed each month to identify any patterns and trends. These reviews were recorded but not on the company's template as staff said it took too long to complete these. The member of staff who championed this activity explained that staff would usually sign the briefing sheet to show that learnings and next steps had been shared with them. And it would be displayed in the dispensary. The sheets for recent months had not been signed by staff. And the previous month's briefing sheet was not displayed in the dispensary during the inspection. This was said to be because the most recent review had just been completed and was due to be posted. The most recent review urged staff to check the quantity of medicine they were dispensing as this was the most common near miss. They were also reminded to use PIFs on all prescriptions.

The pharmacy had the appropriate insurances in place for its services. It asked customers for their views about its services through an annual survey. There was no information displayed in the pharmacy about previous surveys. 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.

A notice showing the name and registration number of the current responsible pharmacist (RP) was clearly displayed. The record showing who the RP had been was complete. Controlled drug (CD) registers were available and entries were up to date. Running balances were kept and were checked regularly. Discrepancies were investigated and had been rectified. The stock of one item was checked and it agreed with the recorded balance. 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, Staff generally used their own NHS smartcards to access electronic prescriptions. They did not share their passwords for these cards. Staff used the consultation room when people needed more privacy.

To protect more vulnerable people, the pharmacy team members had read and signed procedures about safeguarding and this training was refreshed regularly. The RP had completed level 2 safeguarding training. Information about safeguarding support agencies was available to staff in the event they had a concern. The pharmacy described a concern they had raised with a person's GP. This had resulted in additional support being provided to the person.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough, suitably trained staff to provide its services safely. It reviews its staffing needs when new services are planned so it can deliver these services effectively. It supports the training and development of its staff well, through regular training updates and set-aside training time at work. And by enabling its staff to develop their pharmacy careers. Pharmacy staff have appropriate support in place should they need to raise any concerns about the pharmacy. And pharmacy professionals can exercise their professional judgement to act in the best interests of people using the pharmacy's services.

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 pharmacy. One of the pharmacists had been encouraged and supported to train as a pharmacist independent prescriber.

The team comprised two full-time pharmacists, seven trained pharmacy advisors, and one trainee pharmacy advisor. The store manager had arranged for additional staffing in the pharmacy, above the allocated budget, which helped to make sure the pharmacy could expand the services they provided and deliver these safely. There was additional, flexible cover for busy trading times such as Christmas. The team coped with the workload during the inspection and worked closely together.

There appeared to be good communication amongst the staff. The team generally didn't have team meetings but had one-to-one meetings with their managers and each other. Team members said they were able to feedback about operational matters such as stock checking and IT issues. There were closed group social media platforms for staff members to share information and professional updates. There were good handover arrangements in place, so tasks could be completed promptly, and queries resolved.

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. Some training was considered mandatory by the company and this was monitored to make sure it was completed. Staff were provided with some training time at work.

Pharmacists were able to exercise their professional judgement and could make decisions which prioritised patient care. Team members were observed referring requests for Viagra Connect to the pharmacist so he could be closely involved in deciding whether the medicine was appropriate for that person. 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. Staff said they felt able to raise any concerns if needed, and the company had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the services it provides though the storage space for medicines is somewhat cramped. The consultation room provides a private space for people to have conversations about healthcare matters. And the pharmacy has systems to report any maintenance issues.

Inspector's evidence

The dispensary next to the medicines counter was very small and would not have been large enough for staff to assemble all prescriptions. To best manage the space, the team used two, near-patient dispensing terminals closer to the counter but then took the dispensed items back to the pharmacist in the small dispensary for a final accuracy check. The dispensing terminals close to the counter were screened so the public could not see any private information on computer terminals or the prescription forms. Multi-compartment compliance packs were prepared in a separate area, in the stock room. This area was kept locked when not in use, to protect medicines and information from unauthorised access. Only pharmacy staff could access this area.

There was very limited storage capacity for medicines in the dispensary. The recent change in the medication record system had caused an increase in stock holdings. And some of the dispensary drawers were broken. These factors all meant that medicines were not always clearly separated in the drawers or shelves and detracted somewhat from the appearance of the pharmacy. At the time of the inspection, the available space was also restricted by the presence of a large number of delivery containers holding stock. Staff were trying their best to work as safely as possible. And the broken drawers had already been reported to the company's maintenance department. The pharmacy did not yet have a date for this to be completed.

There was adequate lighting and ventilation in the pharmacy. The premises were reasonably clean throughout. Room temperatures could be controlled and were suitable for storing medicines. The dispensary sink used for preparing medicines was equipped with hot and cold running water. The sink was heavily stained. The premises were protected against unauthorised access. Flooring was generally in reasonable condition but one of the comfort mats in the dispensary was lifting in one corner so could pose a trip hazard.

There was a private consultation room located near to the pharmacy. This room was in good condition and offered a suitable space for private conversations and pharmacy services. No private information was left unsecured in this room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works together to make sure the pharmacy's services are safe. It introduces new services in a planned way and its services are accessible to people. The team checks its medicines regularly to make sure they are in-date. And it acts on safety alerts about medicines to make sure its stock is fit for purpose. 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 it doesn't always make these checks when supplying medicines to people who have their medicines delivered. So, it may be missing opportunities to provide people with advice about their medicines.

Inspector's evidence

The layout of the pharmacy and step-free access meant it was wheelchair accessible. There was ample parking available for people visiting the shopping centre. The pharmacy's opening hours were clearly displayed. Leaflets and notices in the retail area provided information about the pharmacy and its services. The pharmacy also signposted people to other sources of support when needed.

The pharmacists offered the Community Pharmacist Consultation Service (CPCS), and the pharmacy were establishing good routines to make sure they checked regularly for any referrals. The right training to administer flu vaccinations had been completed by the pharmacists. There were signed and in-date patient group directions available for this service. Adrenaline ampoules and syringes were available and sharps waste was managed appropriately. One of the pharmacists was also a pharmacist independent prescriber and the pharmacy was in the process of setting up a new paid-for minor ailments service as part of a wider company trial. Ahead of starting this, a risk assessment had been carried out and had looked at the staffing needs and pharmacist cover. As a result of this assessment, additional pharmacist cover was being arranged.

Quite a few people who needed help managing their medicines were provided with multi-compartment compliance packs. Some of these people lived in sheltered accommodation. There was a new SOP to support this activity. For people living in their own homes, the process had been updated to make sure the pharmacy could assess people's needs appropriately. In practice, the pharmacist said he adopted the principles of the new SOP but did not always make the records recommended in the SOP.

The preparation of compliance packs was well-organised, with enough lead time to make sure the packs could be dispensed safely and supplied on time. The pharmacy kept records about medicines, changes to medicines and administration times. There was also a handover book to record messages. Assembled packs included descriptions which allowed individual medicines to be identified. Patient information leaflets were supplied to people every four weeks. The packs and prescriptions had audit trails showing which members of staff had been involved in each stage of the process.

Warfarin and other medicines with variable doses were not included in compliance packs. There was a process to check that people receiving higher-risk medicines were being monitored appropriately for most prescriptions. But the same process was not generally followed for people receiving their medicines in compliance packs or if prescriptions were delivered to people.

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.

Pharmacy-only medicines were stored so they couldn't be self-selected by customers. Stock requiring cold storage was stored in one of two pharmacy fridges. The pharmacy kept temperature records to make sure fridges stayed at the right temperature. Records seen showed that temperatures stayed within the manufacturer's recommended ranges. There was no ice build-up in the fridges. The pharmacy stored CDs appropriately though space was cramped. 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 storage space for some medicines was very limited and meant, in some places particularly on the bottom shelf, there was little separation if any between various medicines. From observation, this made it harder for dispensers to find certain items. And this could increase the chances of dispensers selecting the wrong product.

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, no date-expired medicines were found. The date of opening was added to liquid medicines so dispensers could assess if these were fit for purpose in the future. Date-expired and returned medicines were segregated and placed in pharmaceutical waste bins. The medicines waste bins were kept safely away from other medicines.

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 equipment and facilities it needs to provide its services safely. It checks its equipment regularly to make sure it is safe and working correctly.

Inspector's evidence

There were two dispensary fridges; these provided enough storage capacity for medicines that required refrigeration. Fridge temperatures were checked and recorded daily, and records showed they were operating correctly. The pharmacy had a range of crown-stamped, glass measures for dispensing liquids. These were clean and some were marked for specific uses to prevent cross-contamination. Suitable equipment for counting solid dose forms was available and was clean.

The pharmacy team had access to a range of up-to-date references sources, in hardcopy and online. Patient medication records were held electronically and only pharmacy staff had access to these. Computer terminals were positioned so members of the public could not see people's private information. And the pharmacy had cordless phones so staff could move to quitter areas and hold conversations with people out of earshot of the public.

There was evidence that electrical equipment was safety tested on a regular basis. Fire alarms and other security systems were also checked regularly to make sure they were working properly.

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.