General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Sett Valley Medical Centre, Hyde Bank Road, New Mills, HIGH PEAK, Derbyshire, SK22 4BP

Pharmacy reference: 1029759

Type of pharmacy: Community

Date of inspection: 12/07/2019

Pharmacy context

This is a busy pharmacy located between a medical centre and a dental practice, and across from a clinic with an out-of-hours walk-in centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a small range of over-the-counter medicines. It does not have a private consultation room which limits the services which the pharmacy is able to offer. Around 40% of prescriptions are sent to the company's hub to be dispensed.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their role having been through a thorough induction and training programme. And the pharmacy supports their ongoing learning and development needs.
		2.4	Good practice	Team work is effective and openness, honesty and learning is embedded throughout the team.
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 adequately manages the risks associated with its services to ensure it keeps people safe. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They complete regular checks and make improvements to services. And they make changes to prevent mistakes from happening again. Pharmacy team members generally keep the records required by law, but some details are missing, which could make it harder to understand what has happened if queries arise. They complete training, so they know how to protect vulnerable people and keeps people's private information secure. But could do more to make sure they obtain people's consent before sending their prescription details to the company's hub .

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that all members of the pharmacy team had read and accepted them. SOP compliance audits were completed following the introduction of new SOPs where team members answered questions to check their understanding. SOPs were available in laminated picture versions to suit different learning types. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. Team members were wearing uniforms and name badges were available indicating the team member's role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations. A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services.

Dispensing incidents and near misses were recorded, reviewed and appropriately managed via monthly patient safety reviews. Dispensing incidents were reported on the Boots reporting system 'PIERS' which could be viewed by the pharmacist superintendent's (SI) office and learning points were included. The team had been reminded to always scan green prescriptions to increase the label accuracy following a labelling error. Near misses were reported and all incidents reviewed, and leanings discussed with the pharmacy team at monthly patient safety huddles. The team were currently focusing on accuracy of strength and formulation. Different strengths of levothyroxine and amlodipine tablets had been separated on the dispensary shelves following dispensing incidents. 'Select with care' stickers were used to highlight medicines with different strengths or forms, e.g. diazepam. A dispenser explained she was involved in a near miss with an Epilim product and now always takes extra care when dispensing this medicine to ensure the correct form and strength was selected. The store manager explained that there was also a focus on look alike and sound alike drugs 'LASAs'. There was a list of these on display by the labeller and they were highlighted on the dispensary shelves with 'select and speak it' stickers, e.g. aTENolol and azaTHIOprine. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. A 'Professional Standards Bulletin' was received from head office each month which staff read and signed. It included case studies with points for reflection, root cause analysis and ways to minimise errors.

A pharmacist's log was completed daily and weekly by the RP. The fridge temperature, RP notice, CD security and records etc. were checked as part of this. A weekly clinical governance checklist was carried out by the store manager which included a check on the pharmacy log, confidential information and staffing levels. Action taken was recorded, e.g. the date of the weekly CD balance check.

Two leaflets were available 'Patient Guide' and 'About this pharmacy' which gave details of the complaints procedure and encouraged the public to give suggestions or feedback on the pharmacy services. A customer satisfaction survey (CPPQ) was carried out annually. The results were available on the www.NHS.uk. website. 78% of respondents had rated the pharmacy excellent or very good. Areas of strength (96 to 97%) were staff, service received from pharmacist and offering a clear and well organised layout. An area identified which required improvement (31% dissatisfied) was having somewhere available where you can speak without being overheard. There was a screened area at the counter which offered some privacy and the store manager explained that in some situations she would have a telephone conversation with patients, instead of face to face discussion, and she would stand at the back of the dispensary, so the conversation could not be heard from the retail area. 'Tell us how we did cards' were on the medicines counter and the store manager received this feedback. Recent feedback had been very positive. Following a complaint, the stock levels of some medicines were increased for a particular patient.

Professional indemnity insurance was in place. Private prescription and emergency supplies records were maintained electronically but the computer records were not in a format that could be viewed. The store manager thought this was a technical issue. Subsequent to the inspection, the store manager confirmed that she had reported the issue to IT and it had been escalated. The RP record and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately. Patient details were not always retained with the records for medicines ordered from 'Specials' which could make it harder to find the relevant information if problems arise.

The pharmacy team had completed e-Learning training on information governance (IG) including confidentiality. Prescriptions awaiting collection were not visible from the medicines counter. Information on consent and confidentiality for members of the public to read was in the 'Patient Guide' leaflet. Confidential waste was placed in designated bags which were sealed and collected when full for appropriate disposal. A dispenser correctly described the difference between confidential and general waste. The delivery driver knew what it meant to maintain patient confidentiality. Paperwork containing patient confidential information was stored appropriately. The pharmacy occasionally sent prescriptions to North West Ostomy Supplies (NWOS), a registered dispensing appliance contractor, for them to dispense. Consent to send the patient's details to a third party was not obtained, which risked breaching their confidentiality.

Around 150 to 200 prescriptions each day were sent to a separate off-site pharmacy, the 'Dispensing Support Pharmacy' (DSP). There was a sign informing patients of this, but it was partially hidden, and the store manager said consent was not obtained for this. The address on the medication labels from the DSP stated 'Boots High Peak' rather than the full address of the pharmacy. This might cause confusion as there was more than one Boots branch in the High Peak. There was nothing on the assembled medication highlighting that the prescription had been assembled elsewhere, so people might not be aware of this and this risked breaching patient confidentiality. If a patient requested that their prescription was not sent away then a flash note could be added to their medication record and future prescriptions would be dispensed locally.

The store manager had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Other staff had completed level 1 safeguarding training on e-Learning. The delivery driver said he would voice any concerns regarding vulnerable adults to the pharmacist working at the time. There was a safeguarding notice on display in the dispensary containing the contact numbers of who to report concerns to in the company and also in the local area. Members of the pharmacy team

had completed dementia friends training and so had a better understanding of patients living with this condition. The store manager and a dispenser had been to a recent training event on dementia to improve their understanding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members complete training for the jobs they do. And they do some ongoing learning to help them keep their skills and knowledge up to date. They are comfortable providing feedback to their manager and receive formal feedback about their own performance. Team members have opportunities to discuss issues and there is a procedure in place to report concerns confidentially. The pharmacy enables the team members to act on their own initiative and use their professional judgement to help people who use the pharmacy's services.

Inspector's evidence

There was a pharmacist, two NVQ2 qualified dispensers, one NVQ3 qualified dispenser, a trainee pharmacy advisor and a delivery driver on duty at the time of the inspection. The staff level was adequate for the volume of work during the inspection. Planned absences were organised so that not more than one person was away at a time. Staff absences were covered by re-arranging the staff rota or transferring staff from neighbouring branches.

Staff carrying out services had completed the appropriate training. The staff used the e-Learning system to ensure their training was up to date. Information governance, safeguarding, health and safety, fire training and manual handling were carried out on this system. '30 minute tutors' training packs were available, which were usually clinically focussed. The trainee pharmacy advisor had carried out a comprehensive induction training in a different branch. He explained that the 30 minute tutors packs he had completed at the other branch could not be transferred to this branch, so he was completing the packs again as refreshers. He said he was allocated training time when required to complete training.

Staff were given formal appraisals where performance and development were discussed, and a room was booked at the medical centre or clinic to carry out these discussions. Staff were also given positive and negative feedback informally by the store manager, in between formal reviews. Issues were discussed informally when the pharmacy was quiet, and a dispenser said she felt there was an open and honest culture in the pharmacy. She said she felt comfortable reporting near misses and felt that learning from mistakes was the main focus. A dispenser said she would feel comfortable talking to the store manager about any concerns she might have. She said the staff worked well as a team and could make suggestions or criticisms informally. There was a notice on display in the WC asking staff to report unethical or suspicious behaviour confidentially, with contact details.

The store manager said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations, e.g. refusing to sell a pharmacy medicine because she felt it was inappropriate. She said she felt the pharmacy was adequately staffed and she did not have pressure of having to achieve a certain number of Medicines Use Reviews (MURs), as the pharmacy didn't provide them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy does not have a private consultation room, so members of the public cannot always have confidential conversations. And this limits the services which the pharmacy is able to offer.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean and in a reasonable state of repair. A cleaning rota was used. The retail was free from obstructions and had a waiting area with four chairs. One of the chairs was stained which compromised the professional image of the pharmacy. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a good standard and the fixtures and fittings were in good order. Maintenance problems were reported to head office via 'one number' and the response time was appropriate to the nature of the issue.

The premises were small. Staff facilities were limited to a small kitchen area and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available. The retail area was small. There was no consultation room but there was a partially screened area at the medicine counter. The layout of the counter area was not clear and there was no signage to help direct people. The store manager said people were confused where to hand in and collect prescriptions from. She was observed encouraging a patient to use the screened area when he began discussing his condition and medication in front of other people in the pharmacy. The store manager said regular patients were aware of the lack of consultation room so if they required a private conversation would wait till the pharmacy was empty or telephone the pharmacy. She said she could take the patient into the dispensary, but realised this risked breaching other patients' confidentiality, and would have to move prescriptions out of sight to avoid this.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are generally well managed and easy for people to access. People receive their medicines safely and the pharmacy gives people taking high-risk medicines extra advice. The pharmacy carries out some checks to ensure medicines are in good condition and suitable to supply. But some medicines are not stored as securely as they could be, and there is a risk of unauthorised access.

Inspector's evidence

The pharmacy was accessible to all, including patients with mobility difficulties and wheelchair users. There was a power assisted door. There was a hearing loop in the pharmacy. The pharmacy's opening hours did not reflect the walk-in centre's (opposite) late evening opening hours, as the pharmacy closed at 6.30 pm. So this was not very convenient for users of the walk-in centre who had to travel several miles to the nearest late night pharmacies. Details of the late night pharmacies were available in the walk-in centre.

Services were advertised in the pharmacy and in the 'About this Pharmacy' leaflet. There was a small range of healthcare leaflets and a healthy living notice board with some information about children's oral health. There was some local healthy living information, e.g. 'Live better Derbyshire' and some information on display to help prevent falls. Staff were clear what services were offered and where to signpost to a service not offered e.g. needle exchange or EHC. Signposting and healthy living advice were not recorded unless the pharmacist felt there was a clinical reason, so this was not monitored, and improved patient outcomes were not recorded.

The pharmacy offered a prescription collection service and patients indicated their requirements in advance when they collected their medication. Requirements were checked again at hand-out and any unrequired medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage.

There was a delivery service with associated audit trail. Patients were contacted the day before the delivery so they knew to expect their prescription. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP.

Space was very limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. The dispensary shelves and drawers were reasonably well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail and a quad stamp was completed on the prescription showing who had dispensed, clinically checked, accuracy checked and handed out the prescription. Tubs were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. Pharmacist's information forms (PIFs) and laminated care labels were used to highlight that a fridge line, CD or new medicine had been prescribed. or if any other counselling was required e.g. warfarin or methotrexate prescriptions. Counselling points were printed on the back of the relevant care cards to remind staff of the important

points. INR levels were requested and recorded when dispensing warfarin prescriptions. LASAs were highlighted on the PIF so extra care was taken in the dispensing and checking process. A valproate audit had been carried out and identified no patients in the at-risk group. The valproate information pack and care cards were available to ensure patients who may become pregnant were given the appropriate information and counselling about pregnancy prevention.

There was a colour coded retrieval system so patients not collecting their medication after a month could be easily identified and contacted. The pharmacy provided a text service where patients were informed when their prescription was ready and if they had an uncollected prescription.

Around 40 patients received their medication in multi-compartment compliance aids. These were well managed. A communication book was used to provide an audit trail for communications with GPs and changes to medication, and a copy was put with the patients records. A dispensing audit trail was completed, and medicine descriptions were included on the labels to enable identification of the individual medicines. Packaging leaflets were included. Disposable equipment was used.

A dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. She said she used the mnemonic 'CARE' to remind her of counselling, advising, reading packaging and escalating, when customers asked for specific medicines by name or they recommended a product.

CDs were stored in a CD cabinet which was securely fixed to the wall or floor. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits.

Recognised licensed wholesalers were used for the supply of medicines. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They were not scanning to verify or decommission medicines. The store manager said she thought this would be introduced when they changed to the new computer system in a month or two.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins for storing swaste medicines. But some medicines were not stored as securely as they could be, and there was a risk of unauthorised access.

Alerts and recalls were received from head office via messages on the intranet 'Boots Live'. These were checked daily and acted on by the pharmacist or member of the pharmacy team and then filed when the actions taken had been recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Current British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. Occasions when the fridge had been outside range were recorded on a fridge anomaly sheet, with the action taken. All electrical equipment appeared to be in good working order and had been PAT tested. Any problems with equipment were reported to maintenance help desk.

There was a selection of clean liquid measures with British Standard and crown marks. Separate measures were marked and used for CDs. The pharmacy also had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) Smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.