General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 55-57 Market Street, New Mills, HIGH PEAK, Derbyshire, SK22 4AA

Pharmacy reference: 1029766

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This community pharmacy is located in the town centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	1.2	Good practice	The pharmacy employs a range of review and monitoring mechanisms for staff and the services it provides to help it identify and manage any risks.
		1.4	Good practice	The pharmacy gives people the opportunity to provide feedback and raise concerns. It uses feedback to improve its services and working practices.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports then to address their ongoing learning and development needs.
		2.4	Good practice	Team work is effective and openness, honesty and learning is embedded throughout the organisation.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy proactively manages its services to ensure effective care and to achieve improved outcomes for local people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively identifies and manages risks, so people receive their medicines safely. It completes all the records that it needs to by law and acts on customers views and feedback. 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. Team members keep people's private information safe and complete training, so they know how to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had 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. Team members completed SOP compliance quizzes a week or two after the introduction of new SOPs 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. They were wearing uniforms and name badges showing their 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 were on display.

Dispensing incidents and near misses were recorded, reviewed and appropriately managed via monthly patient safety reviews. Dispensing errors were reported on the Boots reporting system which could be viewed by the pharmacist superintendent's (SI) office and learning points were included. Near misses were reported on a log and discussed with the pharmacy team. A list of Look-alike and sound-alike drugs 'LASAs' were on the dispensary computer and these medicines were highlighted on the dispensary shelves with 'select and speak it' stickers such as 'aTENolol' and 'amLODipine'. Clear plastic bags were used for assembled controlled drugs (CDs) and insulin to allow an additional check at hand out. A monthly patients safety review was carried out by the store manager or RP. It contained an analysis of the near misses which had occurred that month. Most near misses during October had involved the incorrect quantity or strength. It was re-iterated to the team to carry out a thorough self-check before passing to the RP for the final accuracy check. During the review it was highlighted that near misses were occurring when inhalers were prescribed generically when there was a combination of ingredients, so this was pointed out to the team. Near misses had decreased since the introduction of the new computer system (Columbus) as the medicines selected for dispensing were scanned before assembling and any discrepancies highlighted.

A 'Professional Standards Bulletin' was received from head office each month which staff read and signed. It highlighted when new SOPs were introduced and reminded the team of professional requirements. For example, highlighting the importance of reporting concerns to the CD accountable officer, such as CD prescribing issues and unresolved CD discrepancies, which might indicate a dispensing error. It also included a case study with learning from an incident in a different pharmacy. For example, a patient receiving the flu vaccination had indicated on the form that she had no allergies, but was actually allergic to one of the ingredients, and suffered an anaphylactic reaction. Allergies should have also been checked verbally with the patient to ensure the information entered on the form

was correct. This incident occurred after the pharmacist had completed several other flu vaccinations in succession. The SI stated in the bulletin that flu vaccinations should be booked in a realistic schedule which doesn't compromise patient safety. The RP explained that this was sometimes unavoidable as patients were able to book their appointment online themselves. She said it was possible to block out certain times of the day such as lunchtime, but there wasn't a facility to put in rules such as not allowing more than three vaccinations in a row. The RP said she came in on her day off one Saturday because thirteen patients were booked in for flu vaccinations, but the locum pharmacist was not trained and so could not carry them out. She said she preferred to do this rather than cancel and rearrange thirteen appointments.

A poster on 'model day' was on display in the dispensary which contained a list of daily, weekly and monthly checks. A pharmacist's log was completed daily and weekly by the RP. The fridge temperature, RP notice, CD security and CD records were checked as part of this. Daily and weekly clinical governance checks were carried out by the store manager or RP which included a check on the pharmacy log, confidential information and staffing levels. Action taken was recorded. For example, the date of the weekly CD balance check. The area manger carried out audits in the pharmacy which included compliance with SOPs, clinical governance requirements and CD regulations. Areas of non-compliance were highlighted and addressed, such as not consistently completing the quad stamp on prescriptions. There were notices on the symptoms and treatment of fainting, seizures and anaphylaxis and the process to follow after a needle-stick injury or accidental exposure to blood on display in the consultation room. And adrenaline injections were available. This was to help manage the risk associated with the flu vaccination service.

There was a 'handling a customer complaint' SOP. 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 Patient Guide leaflet was provided to every patient receiving a private service. A customer satisfaction survey (CPPQ) was carried out annually. The results of the most recent survey were available on www.NHS.uk website. 76.6% of respondents had rated the pharmacy very good or excellent. Areas of strength (96-98%) were providing an efficient service, staff overall and being polite and taking time to listen. An area identified which required improvement was the comfort and convenience of the waiting area (20.2% dissatisfied). The pharmacy's published response was that they were constantly looking for ways to improve the store environment. The pharmacy team confirmed that there were plans for a refit in the pharmacy. 'Tell us how we did cards' were on the medicines counter and the store manager received this feedback and shared it with the team. Recent feedback had been generally positive but there had been an issue with patient's mobile phone numbers which were not automatically transferred to the new computer system. This had meant the pharmacy was not able to text people to inform them that their prescription was ready to collect. Action was taken to resolve this by checking all patients who had opted for the text service, had a mobile phone number on the system, and writing 'TEXT' on the pharmacist's information form (PIF) with their prescription if they did not, so the member of team handing out the prescription was able to explain the situation and ask for their mobile number. Waiting time to be served was highlighted as requiring improvement, so the pharmacy scheduled two people onto the medicine counter as much as possible, and always at the busiest times of the day.

Professional indemnity insurance was in place. Private prescription and emergency supply records, 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.

The pharmacy team had completed 'e- Learning' training on information governance (IG), data protection and confidentiality and this was refreshed annually. Assembled 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 collected in designated bags which were sealed and then collected and taken for appropriate disposal. A dispenser correctly described the difference between confidential and general waste. Paperwork containing patient confidential information was stored appropriately. The pharmacy sent some patient's prescriptions to North West Ostomy Supplies (NWOS), a registered Dispensing Appliance Contractor, for them to dispense. Consent to do this was obtained on each occasion and a card was given to patient explaining this.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Other members of the team had completed training at a level appreciate to their role. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a safeguarding policy and information and contact details about safe guarding in Derbyshire. The pharmacy had a chaperone policy, and this was highlighted to patients. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Good practice

Summary findings

Team members are well trained and work effectively together. The pharmacy encourages them to keep their skills up to date and supports their development. They are comfortable providing feedback to their manager and receive feedback about their own performance. The pharmacy enables the team members to act on their own initiative and use their professional judgement to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was a regular pharmacist, who was working as the RP, two NVQ2 qualified dispensers (or equivalent) and a trainee dispenser on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. Staff absences were covered by re-arranging the staff hours or transferring staff from neighbouring branches. The store manager who was also a qualified dispenser was not present at the inspection. One of the pharmacy team was on long term sick leave and an accuracy checking technician (ACT) was on maternity leave. Two dispensers from a neighbouring branch were routinely covering hours in the pharmacy due to these absences.

Staff carrying out services had completed appropriate training. The team used various sources including the company's e-Learning system and CPPE to ensure their training was up to date. Regular training was completed to update product knowledge, and assessments were undertaken to check learning. Examples of recent topics covered were children's oral health, flu, risk management and HUG customer care training (Hello, Understanding and Go the extra mile). Health and safety, fire training and manual handling were carried out on the e-Learning system. The pharmacist had also competed training on sepsis and LASAs. The trainee dispenser explained that her course included training on over-the-counter medicines. She used 'Counter intelligence' booklets which were also accessible online through the new computer system. The trainee dispenser was given time to complete her training and felt well supported by the RP who was her tutor. One of the dispensers who had just completed her training course was given two hours of protected training time each week.

The team used the 'WhatsApp' messenger system to communicate when they were not at work and there was also a communication book for use when working. The team were given quarterly reviews where performance and development were discussed, and regular informal feedback from the pharmacist and store manager. Informal staff meetings were held where a variety of issues were discussed, and concerns could be raised. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the rest of the team, pharmacist and store manager about any concerns she might have. She said the team could make suggestions or criticisms informally and felt comfortable admitting and discussing errors. There was a whistleblowing policy and a notice on display explaining this, and a separate notice asking staff to report unethical behaviour with contact details.

The pharmacist said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine because she felt it was inappropriate. She said targets were set for services such as Medicines Use Review (MUR) and New Medicine Service (NMS) but she felt these were achievable and didn't feel targets would ever

compromise patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean and in a reasonable state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office via 'one number' and the response time was appropriate to the nature of the issue. The pharmacy was expecting a refit in the near future as a lack of space in the prescription retrieval area had been identified and was to be addressed.

Staff facilities included a small kitchen area, and a WC with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available. There was a consultation room equipped with a sink. It was uncluttered, clean and professional in appearance. However, a musty smell detracted from the professional image. The availability of the room was highlighted by a sign on the door. Staff used this room when carrying out the services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are effectively managed and easy for people to access. The pharmacy team members give advice and make extra checks when people are receiving higher-risk medicines, to make sure they take them in the right way. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were 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 and a sign showing this. A list of the services provided by the pharmacy was shown in the 'About this Pharmacy' leaflet and displayed in the window of the pharmacy along with the opening hours. Team members were clear what services were offered and where to signpost to a service not offered. For example, emergency hormone contraception (EHC) which could be purchased but was available without charge from the local walk-in centre. The pharmacy had a range of healthcare leaflets and a healthy living zone with information on children's oral health and Stopping smoking. There were some posters advertising local services. For example, a local breastfeeding support group. The pharmacy offered supervised medication and a needle exchange service for a small number of patients and the pharmacy had a good working relationship with the local substance misuse clinic. There had been some success stories with patients reducing their dose of buprenorphine until they came off it completely.

The pharmacy offered a prescription ordering service, although one medical practice did not allow this and so their patients were required to order their prescriptions themselves. Patients ordering through the pharmacy indicated their requirements in advance when they collected their medication. Requirements were checked again at hand-out and any unwanted medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. 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.

Several clinical audits were taking place and patients had been identified for discussion who were taking lithium, non-steroidal anti-inflammatory drugs (NSAIDS) or valproate. An audit of patients with diabetes was also taking place. Five or six people had been referred to their GP surgery as they had not had retinopathy eye or foot checks in the last twelve months. The RP gave examples of several interventions she had made following MURs which had led to good outcomes for patients. For example, referring people to their GP for gastric protection when taking NSAIDs, and for heart checks when taking combinations of medicines which prolonged the QT interval, if they hadn't been checked. She also referred patients for asthma reviews when requesting emergency supplies of inhalers as this was often given as the reason for running out.

Space was adequate in the dispensary and the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and

checked by boxes were initialled on the medication labels to provide an audit trail, apart from methadone and buprenorphine where only the pharmacist's initial was present on the label. The RP admitted that these were sometimes assembled and checked by the pharmacist alone but said she would ensure a competent person carried out a second check when possible. 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. Patient intervention forms and laminated care labels were used to highlight that a fridge line, CD, warfarin, methotrexate or new medicine had been prescribed, or if any other counselling was required. 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. The team were aware of the valproate pregnancy prevention programme. The RP said there were no patients in the at-risk group but was carrying an audit to check this. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Around 70 patients received their medicines in multi-compartment compliance aid packs. These were organised into four weekly groups to effectively manage the workload. There was an audit trail for communications with GPs and changes to medication. A communication record was completed when any changes were made. A dispensing audit trail was completed, and medicine descriptions were included on the labels to enable identification of the individual medicines. Staff confirmed packaging leaflets were included, so patients and their carers could easily access required information about their medicines. Disposable equipment was used.

The trainee 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 understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. The mnemonic 'CARE' was used to remind staff of the importance of Counselling, Advising, reading packaging and Escalating if necessary, when customers asked for specific medicines by name or they recommended a product.

CDs were stored in three CD cabinets which were securely fixed to the wall. A fourth cabinet was available but not used as it was not conveniently located. The CD keys were under the control of the responsible pharmacist during the day and stored securely overnight. A CD log was used to monitor the movement of the CD keys. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. 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. They were waiting for further advice from head office. 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. Alerts and recalls were received from head office via messages on the intranet. These were read and acted on by the pharmacist or member of the pharmacy team and then filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the 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. All electrical equipment appeared to be in good working order and had been PAT tested. Any problems with equipment were reported to the maintenance help desk or re-ordered. There was a selection of clean liquid measures with British Standard and crown marks. Separate measures were marked and used for liquids other than methadone solution. The pharmacy also had a range of equipment for counting loose tablets and capsules. They were not very clean, but a dispenser washed them immediately when this was pointed out. They were not used very often as most medicines were supplied in original packs or foil strips. A dispenser said she would always where disposable gloves if she was required to handle 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.