General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 20 Belle Vue, BUDE, Cornwall, EX23 8JL

Pharmacy reference: 1030032

Type of pharmacy: Community

Date of inspection: 30/04/2019

Pharmacy context

The pharmacy is located on the high street of Bude, a seaside town popular with tourists. It has a large retail area selling health and beauty products. A designated healthcare area is at the rear of the store. The pharmacy dispenses NHS and private prescriptions. It supplies medicines in multi-compartment compliance aids for people to use both in their own homes and in care homes. It also offers advice on the management of minor illnesses and long-term conditions. The pharmacy also offers flu vaccinations, emergency hormonal contraception, medicines for minor ailments and drug user services.

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	1.8	Good practice	The pharmacy has good safeguarding procedures in place and can demonstrate having used these.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages risks well. It reviews its practices to make them safer and more efficient. Team members record their errors and learn from them to stop them happening again. Staff are clear about their roles and responsibilities. They work in a safe and professional way. The pharmacy asks people for their views and acts appropriately on the feedback. It has appropriate insurance for its services. The pharmacy generally keeps up-to-date records as required by the law. The pharmacy keeps people's private information safe and explains how it will be used. Pharmacy team members take necessary action to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had two separate dispensaries. The first was in the main shop and was used to dispense walk-in prescriptions and those collected from local surgeries. The second upstairs dispensary was dedicated for the preparation of multi-compartment compliance aids supplied to people living in their own homes and in care homes.

The pharmacy had processes in place to monitor and reduce risks. Near misses were routinely recorded on a paper log and contain details of the error but little reflection on the cause or the learning points. Separate logs were held in each dispensary. These were jointly reviewed each month. Dispensing incidents recorded on the pharmacy incident and error reporting system (PIERs). A recent incident involving ramipril tablets and capsules had led to the separation of the stock on the shelves. Shelf edge alerts were used following near misses, for example in the locations of prochlorperazine and procyclidine.

A monthly patient safety report was completed which contained a review of all near misses and dispensing incidents and led to the generation of an action plan to reduce errors. The action plans generated through the patient safety report were shared with all team members through a team huddle and through individual briefings. The most recent action plan had encouraged dispensary staff to write the quantity on the box when counting out tablets as an additional check. In the care home services dispensary, the priming process had been reviewed to try and reduce labelling errors.

Caution labels were seen on several shelf-edges, including the locations of amitriptyline and amlodipine, as part of the company's 'look alike, sound alike' (LASA) campaign. Laminated signs were displayed on computer terminals listing the 12 drugs highlighted as high risk by the superintendent's office: quinine, quetiapine, atenolol, allopurinol, amlodipine and amitriptyline, prednisolone, propranolol, carbamazepine, carbimazole, azathioprine and azithromycin. All staff were briefed to say the name of LASA drugs out loud when picking to try and reduce errors. The team used the 'Pharmacist Information Forms' (PIFs) that were attached to all prescriptions to alert the pharmacist to these drugs and the strength dispensed.

The pharmacy team received and reviewed the monthly professional standard document supplied by the company's head office. A locally produced clinical governance document was also reviewed which outlined common themes across the region.

SOPs were up to date and had been recently reviewed and adopted by the regular responsible pharmacist (RP), and had been signed by staff. The SOPs covering RP regulations had recently been reviewed and had been read by all staff. A pharmacy advisor could describe the activities that could not be undertaken in the absence of the RP. Staff had clear lines of accountabilities which were documented in the RP SOPs. They were clear on their job role and wore name badges.

Feedback was obtained by a yearly Community Pharmacy Patient Questionnaire (CPPQ) survey, and by handing customers cards inviting them to complete an online survey. A complaints procedure was available in the practice leaflet which was displayed in the retail area. A recent complaint regarding the failure of staff to update a person's exemption had been responded to accordingly. The manager had changed to process used to check and record exemptions to prevent a reoccurrence.

Indemnity insurance was provided by the XL Insurance Company SENPA and expired on 30 June 2019. RP records were maintained in a log and the correct RP certificate was displayed. The pharmacy regularly used advanced declarations to allow dispensing activity to occur in the absence of the RP. However, these did not always match the entries made in the RP log. For example, on 25 March 2019 an advance declaration was signed by the pharmacist to cover 7.30am to 9am. The RP log entry for that day showed that the RP signed in at 9am.

Records of emergency supplies and private prescriptions were held on the patient medication record (PMR) system, Nexphase. Emergency supplies were generally made through a locally commissioned service and were also recorded on Pharmoutcomes. Records of the supply of unlicensed specials medicines were maintained and were in order.

Controlled drug (CD) registers were maintained as required by law. Balance checks were completed weekly, and a random stock balance check was accurate. Patient returns were recorded in a separate register and were destroyed promptly, and records were kept with two signatures.

All staff had completed training on information governance and the General Data Protection Regulation. Patient data and confidential waste was dealt with in a secure manner to protect privacy. But the storage arrangements of the retrieval system meant that confidential information on prescriptions awaiting collection could be seen by waiting customers. The manager resolved to source deeper shelf fronts to rectify this. A privacy policy and a fair data use statement were displayed in the patient area and confidential waste was segregated appropriately. Verbal consent was obtained from patients prior to accessing their summary care record and a note was placed on the patient medication record (PMR) stating the reason for access. NHS Smart cards were used appropriately.

All staff were trained to an appropriate level on safeguarding. The RP and the pharmacy technician had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training. The remaining staff had completed level 1 e-Learning provided by the company.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff. Team members are well trained for their roles. They keep their skills and knowledge up to date and are supported in their development. Team members suggest and make changes to improve their services. They communicate well with each other.

Inspector's evidence

Staffing levels were adequate on the day of the inspection and consisted of the RP, an accredited checking pharmacy technician (ACPT), four NVQ2 trained pharmacy advisors, a medicines counter assistants (MCAs) and several customer advisors. The store manager was an NVQ2 trained pharmacy advisor who was currently completing her NVQ3 training.

Rotas were completed four weeks in advance to plan for absences, which were usually covered by rearranging shifts, or by part-time staff increasing their hours. In an emergency, the manager would call on support from other local stores.

The team had a good rapport and felt they could manage the workload with no undue stress and pressure. The staff had clearly defined roles and accountabilities which were detailed in standard operating procedures, and tasks and responsibilities were allocated to individuals on a daily basis.

The pharmacy team reported that they were allocated protected time to learn during working hours. Resources accessed included the 30 minute tutors supplied by the company, e-Learning packages and revised SOPs. The RP and the manager were due to attend an off-job training day the day after the inspection. Staff were set yearly development plans and received regular ad-hoc feedback on their performance.

Staff were seen to offer appropriate advice when selling medicines over the counter. The MCA was observed referring to the pharmacist when she was unsure.

The staff felt able to raise concerns and give feedback to the store manager and the RP, both of whom they found to be receptive to ideas and suggestions. Team members were aware of the escalation process for concerns and a whistleblowing policy was in place. The RP described that she felt supported by the store manager and the stores in the wider area. She was in regular communication with pharmacists working in nearby stores.

The RP said the targets set were manageable and that they did not impede her professional judgement. The RP said that she would only undertake services such as MURs that were clinically appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy is small and some fixtures and fittings are dated. This means the pharmacy may not be big enough if the business grows.

Inspector's evidence

The pharmacy was on the high street of Bude, a busy seaside town popular with tourists. There was a large retail are. The healthcare counter and dispensary were at the rear of the shop. As described in principle one, a separate dispensary was located upstairs and was dedicated for the preparation of multi-compartment compliance aids.

The pharmacy had recently had maintenance work completed to remove a bird and bird mite infestation. There was no evidence of any infestation remaining.

A consultation room was available which was of an appropriate size, but it did not have a computer terminal installed. It was soundproofed and was locked when not in use. No patient information was stored in the consultation room.

The main dispensary was very small and the fixtures and fittings were dated. Stock was stored neatly on shelves and in sliding cabinets. Space was limited. There was one computer for labelling and one on the reception bench.

The second dispensary was spacious and well maintained, as were the other areas of the store including the staff room and the offices. Cleaning was undertaken by pharmacy staff and the pharmacy was clean on the day of the inspection. The benches were clear of clutter. The pharmacy was light and bright, and temperature was controlled by an air-conditioning unit.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible and advertises its services well. Medicines are supplied safely and the pharmacy gives additional advice to people receiving high-risk medicines. The pharmacy delivers medicines to people safely and keeps appropriate records of this. The pharmacy obtains its medicines from reputable suppliers. They are stored securely and regularly checked that they are still suitable for supply. The pharmacy deals with medicines returned by people appropriately.

Inspector's evidence

The pharmacy and consultation room were wheelchair accessible. Adjustments could be made for people with disabilities, such as producing large print labels. A hearing loop was available. Services provided by the pharmacy were advertised on the outside of the pharmacy and the RP was accredited to provide all promoted services.

A range of health-related posters and leaflets were displayed and advertised details of services offered both in store and locally. A pharmacy advisor described how if a patient requested a service not offered by the pharmacy, she would refer them to other nearby pharmacies, calling ahead to ensure the service could be provided there. A signposting folder was available with details of local agencies and support networks.

Baskets were used to store prescriptions and medicines to prevent transfer between patients as well as organise the workload. There were designated areas to dispense walk-in prescriptions and those collected from the GP practice. The labels of dispensed items were initialled when dispensed and checked.

Coloured laminates were used to highlight fridge items and CDs in schedule 2 and 3 including tramadol. Prescriptions for schedule 4 CDs were annotated to highlight the 28 day expiry. Prescriptions containing high-risk medicines or paediatric medicines were also highlighted with laminates. The RP described that she checked if patients receiving lithium, warfarin and methotrexate had had blood tests recently, and gave additional advice as needed. Records of results were usually made on the patient medication record (PMR), as were details of significant interventions.

The RP had completed an audit of people who may become pregnant receiving sodium valproate as part of the Valproate Pregnancy Prevention Programme. Three patients had been identified who met the eligibility criteria for the pregnancy prevention programme. Additional counselling had been given to these people and records had been made on the PMR. Stickers were available for staff to apply to the boxes of valproate products for any people who may become prergnant, and information cards present to be given to eligible patients at each dispensing.

Compliance aids for patients based in the community were prepared by the pharmacy. Each compliance aid had an identifier on the front, and dispensed and checked signatures were available, along with a description of tablets. Patient information leaflets (PILs) were supplied each month. ‘When required’ medicines were dispensed in boxes and the pharmacy advisor was aware of what could and could not be placed in compliance aids. But she said that there was one person for whom she blister-packed Epilim tablets, which were hydroscopic and should not be removed from the blister. When questioned,

the RP was unaware that this was happening as the packs were checked by the ACPT and resolved to remedy it as soon as possible. A record of any changes made was kept on the patient information sheet, which was available for the pharmacist during the clinical checking process.

Care homes receiving medication from the pharmacy were supplied with MAR sheets. The majority of care homes were supplied with patient packs. A dedicated care services pharmacist carried out advice visits regularly and provided additional support as needed.

The patient group directions (PGDs) for the supply of emergency hormonal contraception and for the minor ailments service were seen, were in date and had been signed by the relevant staff.

Prescriptions containing owings were appropriately managed, and the prescription was kept with the balance until it was collected.

Stock was obtained from reputable sources including Alliance and AHH. Specials were obtained from Alliance Specials. Invoices were seen to this effect.

The pharmacy did not have the required hardware, software or scanners to be compliant with the European Falsified Medicines Directive (FMD).

The dispensary shelves used to store stock were generally organised and tidy. The stock was arranged alphabetically. Date checking was undertaken each week and the entire dispensary was checked every three months. A tracking sheet was completed detailing stock that was due to expire in the coming months. Spot checks revealed no date expired stock or mixed batches.

CDs were stored in accordance with legal requirements in an approved cabinet. Denaturing kits were available for safe destruction of CDs. Expired CDs were clearly marked and segregated in the cabinet. Patient returned CDs were recorded in a register and destroyed with a witness with two signatures were recorded.

The dispensary fridges were clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range of 2 to 8 degrees Celsius.

Logs were kept of deliveries made to patients based both in the community and in care homes with appropriate signatures. Confidentiality was maintained when obtaining signatures. The manager described the process followed in the event of failed deliveries to ensure that patients received their delivery in a timely manner, particularly those considered to be vulnerable.

Patient returned medication was dealt with appropriately. Confidential patient information was generally removed or obliterated from patient returned medication. Records of recalls and alerts were seen and were annotated with the outcome, the date and who had actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It keeps these clean and tidy. The pharmacy stores its completed prescriptions in a way that means people's private information could be seen by the public.

Inspector's evidence

Validated crown-stamped measures were available for liquids, with separate measure marked for the use of controlled drugs only. A range of clean tablet and capsule counters were present, with a separate triangle clearly marked for cytotoxics. Reference sources were available and the pharmacy could also access up-to-date information on the internet.

All equipment, including the dispensary fridge, was in good working order and PAT test stickers were visible and were in date. The dispensary sinks were clean and in good working order. Computers were positioned so that no information could be seen by customers, and phone calls were taken away from public areas. Dispensed prescriptions were stored in a retrieval system on shelves. As described in principle one, the names and addresses of people could be clearly seen from customer areas.

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.