General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 48A Bath Street, ILKESTON, Derbyshire, DE7 8FD

Pharmacy reference: 1030440

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This high street pharmacy is located in the centre of town and 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

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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 employs a range of review and monitoring mechanisms for staff and the services it provides to help it identify and manage any risks.
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 them 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 help 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 manages risks to make sure its services are safe and acts to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. The pharmacy has written procedures on keeping people's private information safe and team members understand how they can help to protect the welfare of vulnerable people.

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. SOP compliance quizzes were completed following the introduction of new SOPs where team members answered questions to check their understanding. SOPs were available in laminated picture version to suit different learning types. Roles and responsibilities were set out in the SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges indicating 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. Dispensing incidents and near misses were recorded, reviewed and appropriately managed via monthly patient safety reviews. The details of the most recent patient safety review was on display in the dispensary and showed the agreed actions that the team would deliver over the coming month. This included the pharmacy team staying focused, avoiding distractions and monitoring look-alike and sound-alike drugs 'LASAs'. A list of 'LASAs' were positioned near to the dispensary computers and these medicines were highlighted on the dispensary shelves with 'select and speak it' stickers. For example, 'quetiapine' and 'quinine'. Quetiapine had been placed in a separate part of the dispensary, away from quinine. Other medicines identified as at higher risk of picking error were also segregated. LASAs were highlighted on pharmacist's information forms (PIFs) which were placed with every prescription, and the pharmacist made an extra check that the correct medicine had been selected each time. The RP explained that if a LASA was not highlighted on the PIF then this was considered a 'near miss,' and recorded on the near miss log. 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. Near misses were reported and discussed with the pharmacy team. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out.

A poster called '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, controlled drug (CD) security and records were checked as part of this. A weekly clinical governance checklist was 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. 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 case studies with learning from incidents in different pharmacies. 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. A notice on the principles for safe dispensing of methadone was above the bench where methadone was assembled and a notice showing the four key steps to patient safety was in the area used to assemble compliance aid packs. These had both been in previous issues of the professional bulletin and gave ways to minimise errors. There were notices displayed in the consultation room explaining the symptoms and treatment of fainting, seizures and anaphylaxis and the process to follow after a needle-stick injury or accidental exposure to blood. This helped the team to manage the risks associated with the flu vaccination service.

There was a 'handling a customer complaint' SOP. 'About this pharmacy' leaflets were available 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 of the most recent survey were available on www.NHS.uk website. Results indicated 94.7% of respondents had rated the pharmacy very good or excellent. Areas of strength (100%) included staff overall, being polite and taking time to listen and the cleanliness of the pharmacy. An area identified which required improvement (13.3% dissatisfied) was the comfort and convenience of the waiting area, but this had not resulted in any changes or improvements being made to this area. 'Tell us how we did cards' were available to be given out to people but were not freely available, so, people might not realise this was an option. The store manager received any feedback and shared it with the pharmacy team.

Professional indemnity insurance was in place. Private prescription and emergency supply records, the RP record, and the 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. A dispenser correctly described the difference between confidential and general waste. Confidential waste was collected in blue bags which were sealed when full and sent to head office for disposal. Assembled prescriptions awaiting collection were not visible from the medicines counter.

The RP had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Other staff had completed training appropriate to their role. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The contact numbers of who to report concerns to in the local area and within the company were available. The RP understood the procedure for reporting and realised it was her duty to report concerns. She had escalated a concern to the appropriate authorities following an incident at a different pharmacy. 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. There was a notice on display highlighting a dementia support group.

Principle 2 - Staffing ✔ Good practice

Summary findings

Team members are well trained. They work well together and communicate effectively. They are comfortable providing feedback to their manager and receive feedback about their own performance. The pharmacy supports the development of team members and enables them to act on their own initiative and use their professional judgement.

Inspector's evidence

There was a regular relief pharmacist, three NVQ2 qualified dispensers (or equivalent) and two medicines counter assistants (MCAs) on duty. The staffing level was adequate for the volume of work during the inspection. Planned absences were organised to ensure adequate staff levels and when necessary the staff rota was re-arranged. There was flexibility within the team and the option of transferring staff from neighbouring branches. One of the dispensers working at the time of the inspection was from a neighbouring branch, covering a long-term absence. The store manager was a qualified dispenser so she could assist in the dispensary when necessary, and there was an additional dispenser and MCA who were part of the pharmacy team, although not present at the inspection. The relief pharmacist worked regularly one day each week at the pharmacy.

Team members carrying out services had completed the appropriate training. They used the company's e-Learning system to ensure their knowledge was up to date and training was completed regularly. Assessments were undertaken to check learning. Examples of recent topics covered by the team were children's oral health and Viagra connect. Health and safety, fire training and manual handling were also carried out on the e-Learning system. A dispenser explained that she was going to do some training on sepsis after reading something in the Professional Bulletin about the risk of sepsis with infections such as cystitis. A large amount of training had been completed before the introduction of the new computer system 'Columbus'. There had been a work booklet to complete and face to face training by a representative from another branch.

There were regular conference calls with other branches in the area and information was cascaded by the store manager or delegate to the pharmacy team. A notice board was used to highlight information such as the monthly patient's safety review. There were regular huddles with the store manager, who had also set up a WhatsApp group to share messengers within the pharmacy team. There had been a recent meeting before work, discussing Christmas and the increased work load expected, and explaining the required changes which were needed to the staff rota because of this.

Team members had formal discussions with their manager about performance and development and were also given positive and negative feedback informally. A dispenser said she felt there was an open and honest culture in the pharmacy and 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. The RP said she had made several suggestions which had been acted on. For example, ringing patients first before delivering their medicines to check the most convenient day, in order to avoid failed deliveries. She said this had not been an issue since the charge for deliveries had been introduced. There was a whistleblowing policy and a notice on display showing this.

The RP said she was comfortable reporting errors and that learning from mistakes was encouraged. She said she was 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 team targets were set for services such as Medicines Use Review (MUR) and New Medicine Service (NMS), which she helped to achieve. These were closely monitored in the organisation, but she didn't feel under excessive pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private room that enables members of the public to have consultations in private. But people may not be aware of this facility and team members do not necessarily offer people the opportunity to use it.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean, spacious, well maintained and in a good state of repair. The retail area was free from obstructions and professional in appearance. There wasn't a dedicated waiting area but there was one chair positioned near the prescription reception desk. 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.

There was a large separate stockroom where excess retail stock was stored. Staff facilities included a staff room with a kitchen area and several WCs with wash hand basins and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available. Disposable gloves were worn when assembling MDS.

There was a large consultation room which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door, but the location of the room meant that it could not be seen from the retail area, so people might not realise the facility was available. Staff explained they would use this room when carrying out services such as MURs and when customers needed a private area to talk. There was an area at the end of the prescription reception desk which could be accessed from a hatch in the dispensary. This was generally used for patients receiving supervised medication. However, the area was not screened, and people could be clearly seen from the retail area, which did not protect their dignity. The RP said she would use the consultation room if asked, but did not routinely offer this to these patients, as this was not the usual practice at this pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. Services are well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out some 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 an automatic 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 'About this Pharmacy' leaflets which were on display. Some services were advertised in the window of the pharmacy along with the opening hours. There was a range of healthcare leaflets. There was healthy living zone opposite the consultation room, but this was not within the main retail area, so not seen by most people visiting the pharmacy. It contained posters advertising the flu service and 111 service. Staff were clear what services were offered and where to signpost to a service not offered. For example, needle exchange. A folder was available containing relevant signposting information which could be used to inform patients of services and support available elsewhere.

The pharmacy offered a prescription collection service for some patients and they were contacted before their prescriptions were due, to check their requirements. This was to reduce stockpiling and medicine wastage. Not all patients could be offered this service as some GP surgeries in the area did not allow it. 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 or if they had an uncollected prescription. There was a home delivery service with associated audit trail. A fee was charged for the service. 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 dispensary was spacious 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. 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. 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. For example, warfarin, methotrexate and medicines for children. 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 pharmacist was required to carry out an extra check of the age and dose for all children's prescriptions. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one patient in the at-risk group had been identified. This patient had been counselled about pregnancy prevention and there was a note on their patient medication record (PMR) confirming 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.

Several audits were taking place and laminated cards or 'can we have a chat' notes were used to highlight the patients for inclusion in the audits. These included patients prescribed non-steroidal anti-inflammatory drugs (NSAIDS), valproate or methotrexate and patients diagnosed with diabetes or asthma. Two people had been referred to their GP surgery as they had not had retinopathy eye or foot checks in the last twelve months, as part of the diabetes audit and the RP had referred at least one patient for asthma reviews as part of the asthma audit.

Around 80 patients received their medication in Multi-compartment compliance aid packs. They were assembled and stored in a large separate area at the rear of the dispensary. The process was well organised with an audit trail for communications with GPs and changes to medication. A communication record book was used to record relevant conversations with the patient, their carer or their GP surgery, and a copy filed with the patient's records. A note was also made on the PMR. 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, so patients and their carers could easily access required information about their medicines. Disposable equipment was used and disposable gloves were worn when assembling the packs.

An MCA 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 CD cabinets which were securely fixed to the wall/floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Around 25 patients received supervised medication. Around seven days of supplies were assembled at a time and they were stored, clearly labelled, in a separate CD cabinet. The process was well organised with a robust dispensing audit trail. 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 currently scanning to verify or decommission medicines. They were waiting for advice from head office and had not received any training on this yet.

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. A notice highlighting that the pharmacy took back unwanted medicines for disposal was on display. 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 clean and safe to use.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children, Martindale and Stockleys were available and the pharmacist could access the most up-to-date versions from the intranet. For example, the electronic medicines' complete website. 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 methadone solution. 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. The RP explained that she would wash the triangle after using it to count methotrexate but it was usually obtained in foil strips to avoid handling. A dispenser said she would wear disposal gloves if handling of a cytotoxic was unavoidable. 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.