General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 169 Manford Way, CHIGWELL, Essex, IG7 4DN

Pharmacy reference: 1031044

Type of pharmacy: Community

Date of inspection: 09/04/2019

Pharmacy context

This is a small Boots store located on a high street across the road from a health centre which has two GP surgeries. As well as dispensing NHS prescriptions the pharmacy supplies medicines to approximately 70 people in multi-compartment compliance aids. Flu vaccinations are also provided.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	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's working practices are generally safe and effective. The pharmacy protects people's information and team members understand their role in protecting vulnerable people. The pharmacy asks people for their views. It generally keeps the records it needs to so that medicines are supplied safely and legally.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place and were up to date. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs.

Near misses were brought to the attention of the dispenser who had made the mistake and they were then asked to rectify the error. A record was made on the near miss log by the responsible pharmacist (RP). Contributory reasons were not always recorded. A patient safety review was generally done at the end of each month by the accuracy checking technician (ACT).

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. These were then sent to the store manager for investigation. The RP and ACT described an error in which the wrong person had been given someone else's medication. Both people had very similar names and their road names were also similar. The team had been asked to now confirm postcode and address when handing out prescriptions. For these two individuals the bag label was highlighted and name circled.

The ACT said that she completed a patient safety review each month. As part of this she looked at all the near misses that had been recorded and thought of changes that could be made to avoid reoccurrence. The findings of this were shared with the team. Both the RP and ACT demonstrated that the types of near misses had changed. More recent near misses related to team members either dispensing incorrect quantities or strength. They had found that there were contributory factors resulting from members of the team sometimes rushing or under pressure, with people standing and watching as they waited for their prescription to be dispensed. The patient safety review was looked over by the store manager. As part of the last meeting the team had discussed an incident where the wrong strength of medication had been handed out; because of this all team members were asked to double check their own work and dispense using the prescription. The team had also discussed that Medisure patient records were not up to date and needed to be organised; this was being done by the store manager at the time of the inspection.

As part of the patient safety review the team were asked to read through the Professional Standards Bulletin and had to sign when this had been done. The ACT said that for drugs which looked alike or sounded alike (LASA) the team had been asked to read the product name aloud when picking stock and mark this on the pharmacist information form (PIF). This then needed to be ticked when it was dispensed and signed when the RP checked. The ACT said that head office had identified a list of LASA medicines and lists were stuck on each workstation to prompt the team.

The pharmacy had a complaints procedure in place and details of the customer care team were printed at the back of the receipts. Annual patient satisfaction surveys were also carried out. The team also handed out patient survey cards which could be completed online at any time with feedback sent to

head office, in addition to this, receipts were printed out randomly with details of how people could feedback. Previous feedback received had been about extended waiting times, the team tried to work hard to keep these low. But said that on some occasions for patient safety reasons longer waiting times had to be given.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Professional Indemnity insurance was in place.

Records for private prescriptions, emergency supplies, RP records and controlled drug (CD) registers were well maintained. Records for unlicensed specials were generally well maintained but some records observed were incomplete.

CD balance checks were carried out on a weekly basis. This had previously been done every Saturday but the new store based pharmacist had changed this to be done on Thursdays when there were usually two pharmacists.

A random check of CD medicines complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored on a retrieval system and were not visible to people. An information governance policy was in place and each year the team were required to complete training on the E-Learning system. The team had also completed an E-learning module on the General Data Protection Regulation. Members of the team who worked in the dispensary had their own smartcards. Summary Care Records could only be accessed by the pharmacists; the RP was waiting to receive her code so that she could access these.

The team had completed safeguarding training on the E-learning system; in addition to this the RP had also completed the level 2 training. Details for the local safeguarding boards were available and the team could describe where this could be found. The team would report any concerns to the RP; including sales of Phenergan for children.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides services using team members with a range of skills and experience who support each other. The pharmacy staff levels mean that on occasions the team struggle with the workload. But the pharmacy is taking action to help address this. Although staff have access to training material, the team does not have protected study time. This may mean that they may not always have the opportunities to complete ongoing training and keep their skills and knowledge up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, an accuracy checking technician, two dispensers and a pharmacy advisor. Through the course of the inspection there was a steady stream of people. Team members said that the pharmacy was quieter than normal due to the half term holidays. There was generally one person covering the till and the dispensary team supported when needed. The RP said that between 9am to 11.30am frequently there was no till cover as a result of which the dispensary team had to cover the tills. A number of team members had been on long term sick leave and the team were unsure of when one was due to return.

The RP and team members said that they did not feel that there were an adequate number of staff available. This had been raised with the store manager and area manager. The week prior to the inspection the store had to be closed due to staff shortages. A number of team members had handed in their resignations and two dispensers that had left in October to November 2018 had not been replaced. Although an ACT was available, she said that she was not able to check many prescriptions as she was needed to help dispense. There was a large volume of dispensed prescriptions waiting to be checked which included prescriptions ordered as part of the repeat prescription service. Most of the prescriptions observed in the checking area had been due a number of days prior to that day. The RP said that prescriptions that had been due on that day had been labelled in the morning to ensure that stock would be available if someone presented to collect their prescription. The RP said that the checking had built up as the pharmacist was usually needed at the front counter to deal with walk in prescriptions and queries.

Following the inspection, the clinical governance pharmacist said that the pharmacy had a vacancy which was in the process of being filled; and due to long term sick leave earlier in the year the team had fallen behind. However, all team members had returned and the clinical governance pharmacist was due to arrange extra dispensing and checking cover to bring the pharmacy back on track.

The pharmacy advisor counselled patients on the use of over the counter medicines and asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine and would always refer to the pharmacist if unsure. She described handing out prescriptions in line with SOPs.

The team were provided with regular training modules on E-learning which covered a range of different topics and areas. In addition to this each month the team were sent 30-minute tutors which covered different over the counter conditions or products. This had a QR code which could be used to load the training onto individual’s mobile phones. The team said that there was no time provided to complete training whilst at work and most training was to be done at home unless a deadline was near and team

members had not completed their training.

Pharmacists also had access to Pharmacy Unscripted which had resources available for revalidation.

With the exception of the patient safety review, the team did not have any formal meetings. Each morning the dispensary team held a quick chat to plan the day and identify what needed to be done and focus areas; other issues were discussed as they came up. The team would raise any concerns with the RP, who would then forward them to the store manager. As the RP was a relief pharmacist she said that her first point of contact would be her line manager or rota manager. They would then escalate this matter to the area manager.

Targets were in place for services such as MURs and NMS; there was some pressure on the team to meet these targets. Weekly targets were set and a performance board was used to keep track as targets were not being met. The RP said that she would not provide services if she felt that it would have an adverse effect on patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is a suitable place to provide healthcare. But some of the areas are cluttered and not very tidy. So, there may be more risk of things going wrong.

Inspector's evidence

The pharmacy appeared grubby and some areas such as under shelves on the shop floor had a considerable amount of dust. The dispensary was in the main clean, there was ample workbench space available both at the front and at the back. Workbenches at the back were filled with stock which had been received and prescriptions waiting to be checked. Shelves were available on top of the checking area to store prescriptions waiting to be checked. This also had a large volume of tubs waiting to be checked. A sink was available and medicines were arranged on the shelves in a tidy and organised manner. Owing prescriptions were laid out on the bench with stock placed on top, tubs were not used for this. This had been done as the dispenser was looking for owing stock in the delivery received. Cleaning was done by the team usually at the end of the day. However, the team had struggled to do this. The dispensary cleaning rota had not been updated since the beginning of April.

Multi-compartment compliance packs were prepared in the back area on a designated workbench. This area was only accessible via a keypad lock. There were a number of tubs stored here which contained people’s confidential information and prescription only medicines (POM). The RP said that only the store team had access to this area and any contractors or workmen were accompanied by a team member and not left unaccompanied.

A signposted consultation room was available. This was easily accessible from the shop floor. The door to the room was locked when the room was not in use. Confidential information was held in the room in locked cabinets.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are generally delivered in a safe and effective manner. The pharmacy obtains medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. The pharmacy team do not always provide people with a description of the medication placed in compliance aids. So, patients and carers may not be able to identify which medicines are which. It does not use some of the safety materials (such as warning stickers) for the supply of valproate. This means that people may not always have the information they need to take their medicines safely.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street and one of the doors were power assisted. There was easy access to the medicines counter. The pharmacy had the facilities to print large print labels. The pharmacy had a hearing loop. The team were multilingual and spoke or had an understanding of the main languages spoken locally. The pharmacy team routinely signposted patients to other local services.

The RP felt that the MUR service had the most impact on people. She said from her experience she had come across a number of people who had not been taking their medication as prescribed. She had also had people come back to tell her about the difference her recommendation had made to their conditions.

The pharmacy received a large number of walk in prescriptions as well as prescriptions from surgeries where people had requested their prescriptions themselves. The team said that due to the lack of staff these had to be dispensed at the time that the person presented to the pharmacy to collect. A team member said that another pharmacy down the road gave longer waiting times, as a result of which some people walked over to this pharmacy which then created a backlog of prescriptions waiting to be dispensed. At the start of the day the RP stayed at the front with the pharmacy advisor and managed the walk-in prescriptions; the ACT dispensed all the repeat prescriptions. On the day of the inspection one of the pharmacy advisors who worked three days a week was completing the date checking. The RP did not self-check. When the ACT was working she would ask her to check her work or ask one of the dispensers. On the odd occasion where the RP had to self-check she would take a mental break, give a longer waiting time and check again at handout.

A quad stamp was used which was initialled by all members of the team to create an audit trail for each stage of the dispensing and supply processes. Dispensed and checked by boxes on labels were also used by members of the team. The pharmacy team also used trays and tubs to ensure that people's prescriptions were separated.

The team dispensed sodium valproate in its original pack and highlighted the change in guidance to the person. If the person had not had sodium valproate before the RP would take them into the consultation room to have a consultation. Sodium valproate was highlighted on the PIF and the person was supplied with an information leaflet. The RP was not aware of the need to use the warning stickers if the medicines were not dispensed in its original pack. Audits had been done by the previous store based pharmacist.

When dispensing other high-risk medication, the dispenser said that the warning cards were used and these had prompts on the back relating to the questions that needed to be asked or information that needed to be passed on. INR results were recorded on the patient medication record (PMR) for people who were regularly taking warfarin. Surgeries did not issue prescriptions unless tests had been done.

The pharmacy offered a free repeat prescription service (FRPS) in which prescriptions were ordered for people who were notified when then their medicines were ready to collect. Prescriptions which had been due on 3 April 2019 were waiting to be checked.

The store manager was in the process of sorting out Medisure record sheets and updating any changes for people who had their medicines supplied in compliance aids. The team worked a week in advance when preparing these trays and were not behind with these. Prescriptions were ordered by the pharmacy and on receiving these they were placed in an allocated folder depending on when they were due. Trays were labelled a week in advance to ensure stock was received. Any changes to medication were annotated on the individual record sheet. People came in with a copy of their discharge summary after a hospital admission. Changes in medicines were recorded on the PMR and the surgery were requested to send in information of changes on letter headed paper which was filed with the person's record. Trays were prepared by any of the dispensers and were generally sealed as soon they were prepared; trays with a large number of medicines were left unsealed so that they could be checked. There was an unsealed tray observed in the area used to dispense multi-compartment compliance packs with a note that the team were waiting to receive stock. This could increase the chances of mistakes being made and could affect the quality of the medicines.

Assembled trays observed were labelled with mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly. There were no product descriptions on the two trays sampled.

The pharmacy was not offering any services under a patient group direction at the time of the inspection.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as Controlled Drugs (CDs) and those requiring cold storage. Fridge temperatures were monitored and recorded daily, and these were observed to be within range. CDs were kept under safe custody in the CD cabinet.

The pharmacy had been briefed on the Falsified Medicines Directive (FMD) but equipment had not been installed. The RP was not aware of when this was due to be available to be used in store. This means that it may be harder for the pharmacy to demonstrate that it is complying with current requirements around falsified medicines.

Stock was being checked by a dispenser on the day of the inspection. The team were behind on date checking. Stock going out of date was highlighted with a short-dated sticker, recorded and removed. There were no date expired medicines found on the shelves sampled. Following the inspection, the clinical governance pharmacist confirmed that the date checking had almost been completed.

Out of date and other waste medicines were segregated and then collected by licensed waste collectors. Drug recalls were received directly from the MHRA by the RP and they were also received on Boots Live which the store manager checked when she was in. The RP was unsure as to who checked the alerts when the store manager was absent. The last actioned alert had been for losartan.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a range of clean glass crown stamped measures available. Tablet counting trays were available with a separate counter available for cytotoxic medication to avoid contamination. A separate labelled measure was also available for methadone.

Up to date reference sources were available including access to the internet.

The pharmacy had two fridges of adequate size and a legally compliant CD cabinet.

The pharmacy's computers were password protected and screens faced away from the public. Confidential paperwork/dispensing labels were collected in a confidential waste bag and then sent to head office for destruction.

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.