General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 21 Westbury Mall, Shopping Centre, FAREHAM, Hampshire, PO16 0PE

Pharmacy reference: 1031711

Type of pharmacy: Community

Date of inspection: 08/08/2019

Pharmacy context

This is a community pharmacy located inside a shopping centre close to the centre of Fareham in Hampshire. The pharmacy dispenses NHS and private prescriptions. It offers some services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), Emergency Hormonal Contraception (EHC) and administers travel vaccinations. The pharmacy supplies multi-compartment compliance aids to people if they find it difficult to manage their medicines. It provides medicines to residents in care homes. And, some people's prescriptions are assembled from another part of the company's premises.

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

Overall, the pharmacy manages most risks appropriately. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. They understand how to protect the welfare of vulnerable people. And, they protect people's private information well. The pharmacy adequately maintains some of the records that it needs to. But it is not always recording enough detail. This means that the team may be missing opportunities to spot patterns and prevent similar mistakes happening in future. And, they may not have all the information needed if problems or queries arise.

Inspector's evidence

This was a busy pharmacy. A steady stream of people used the pharmacy's services during the inspection. The team managed the workload and the queues appropriately. The pharmacy's dispensing activity took place in two distinct areas. This included the main dispensary situated in the retail area, and another dispensary where medicines for care homes and multi-compartment compliance aids were assembled.

To help prevent errors from distractions, staff explained that when prescriptions for the care homes were being processed, they used a designated computer terminal that was semi-enclosed and blocked off from other terminals, to help reduce distractions. Staff and pharmacists worked in separate areas and this included a designated area for the accuracy checking technician (ACT). Prescriptions for the care homes and compliance aids when labelled were clinically checked by the pharmacist before being assembled by staff and checked for accuracy. The ACT was not involved in any other process other than the final check, and there was a standard operating procedure (SOP) to cover this process.

Staff recorded their near misses in all the dispensaries. In the care home dispensary, there were individual sheets used for the team members to record their mistakes and individual feedback was provided to each member of staff at the end of the month. The near misses were collectively reviewed every month by the ACT. The company's Patient Safety Review (PSR) was completed as part of the review process, this helped to identify trends or patterns in each of the dispensaries, and details were shared with the team. Look-alike and sound-alike medicines were highlighted. Laminated cards were used to highlight higher-risk medicines and pharmacist information forms (PIFs) were attached to each prescription when assembling them. This provided relevant information when medicines were checked for accuracy or when prescriptions were handed out.

Staff in both dispensaries explained that their near misses had reduced. This was described as due to their awareness being raised about their mistakes, they were re-trained on some procedures, observations were carried out on them by their line managers to verify that team members were operating in line with the SOPs and they were observed to concentrate on their tasks. However, there were missing details in the near miss logs. The reasons for the errors were not routinely being filled in and this was seen for both the care home dispensing as well as in the main dispensary.

Incidents were handled by the pharmacists, assistant managers or the store manager and investigated by the latter. The process was in line with the company's requirements and involved information being recorded on their internal reporting system. There was information on display about the pharmacy's complaints procedure.Team members could identify signs of concern to safeguard vulnerable people.

They had completed the company's e-Learning module and the pharmacists were trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). There were local contact details for the safeguarding agencies and policy information present.

There was no confidential material left within areas that faced the public. Staff segregated confidential waste before this was disposed of through the company and details on dispensed prescriptions awaiting collection were not visible from the retail area. The team was trained on information governance and the European General Data Protection Regulation (GDPR) through completing the relevant e-Learning module. Summary Care Records were accessed for emergency supplies, consent for this was obtained verbally and details were recorded on the person's record. The pharmacy displayed information so that people could be informed about how their privacy was maintained.

At the point of inspection, there was no information on display to inform people that medicines were being dispensed off-site. According to staff, people were verbally informed about this process and they consented to this activity when they signed up for the pharmacy's managed repeat prescription service.

Most of the pharmacy's documented SOPs were in place to support the provision of its services. However, the range of SOPs to provide guidance to the team about the responsible pharmacist (RP) and activities that could take place in the RP's absence were missing. This also meant that the team members roles and responsibilities were not defined as there was no matrix present to cover this. The staff had read and signed the SOPs, they understood their roles, responsibilities and limitations and knew when to refer to the pharmacist. The correct notice for the RP was on display and this provided people with details of the pharmacist in charge of operational activities on the day.

The maximum and minimum temperatures for the fridges were checked every day and records were kept. This verified that temperature sensitive medicines had been stored appropriately. Professional indemnity insurance arrangements for the pharmacy were in place to cover the services provided. Staff kept a record of controlled drugs (CDs) that were returned by people and destroyed by them although there the occasional entry was seen where details of the destruction had not been recorded.

Other than a sample of registers checked for CDs and most of the RP record, the pharmacy's other records were not always maintained in line with statutory requirements. For CDs, balances were checked and documented every week. On randomly selecting CDs held in the cabinet, their quantities matched entries in corresponding registers. There were occasional overwritten entries and one missing entry within the RP record. There were incorrect prescriber details and the types of prescribers recorded in the electronic register for private prescriptions, missing prescriber details within records of unlicensed medicines and the nature of the emergency when providing emergency supplies had not been routinely documented. Some records for the latter, were only marked as 'es given' along with the date that the supply was made with no other information recorded.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members understand their roles and responsibilities. And, they keep their skills and knowledge up to date by completing regular training.

Inspector's evidence

The pharmacy's staffing profile included an ACT, a pharmacy technician and ten dispensing assistants based in the care home section, one of them was full-time and the rest were part-time. There were three full-time dispensing assistants, a medicines counter assistant, an apprentice and a pre-registration pharmacist based in the main dispensary. The latter two were newly employed. Two assistant managers, one for each of the dispensaries were also trained dispensing assistants along with the store manager and there were five pharmacists in total who provided cover at the pharmacy. One pharmacist was usually based upstairs to oversee the dispensing for the care homes and for the compliance aids.

Name badges were worn by staff. Certificates for the team's qualifications obtained were not seen. Staff asked relevant questions before they sold over-the-counter (OTC) medicines and provided advice appropriately. If they were unsure. they asked the RP and they demonstrated sufficient knowledge of OTC medicines. To assist with training needs, the pharmacy's team members used resources from the company such as the e-Learning modules, they read newsletters, completed tutor packs and they read the SOPs. Staff received formal appraisals every six months. Details and updates were regularly conveyed to the team through weekly meetings and communication books were used. The RP explained that there was a target to complete 10 MURs every week, but this was described as manageable with no pressure being applied to complete them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. And, it has separate areas where confidential conversations and services can take place.

Inspector's evidence

The pharmacy premises consisted of a spacious retail area with two dispensaries in the building, one of which was located upstairs and used to prepare medicines for the care homes as well as the compliance aids. Entry into this area could be restricted as key coded access was in place. There was plenty of space in this dispensary to store medicines, process and assemble prescriptions.

The main dispensary was situated downstairs in front of one of the entrances. There were designated sections on the front dispensing counter to assist with processing walk-in prescriptions and a signposted queue system was in operation to direct people appropriately. There was additional workspace in the back section of this dispensary with a hatch for people who required supervised consumption. The area outside the hatch in the dispensary was cluttered with medicines and assembled prescriptions, staff stated that this was cleared before it was used. The hatch was not used during the inspection.

The pharmacy was clean, appropriately presented, suitably bright and ventilated. A signposted consultation room was available for services and private conversations. It was locked when not in use and the space was of an adequate size for the services. Pharmacy (P) medicines were stored behind the front counter and staff were always present to restrict their self-selection.

Principle 4 - Services ✔ Standards met

Summary findings

In general, the pharmacy provides its services safely and effectively. It obtains its medicines from reputable sources. And, the pharmacy team takes extra care with people prescribed high-risk medicines. This helps ensure people can take their medicines safely. But, the pharmacy does not always store all of its medicines appropriately. This makes it harder for staff to check some details, assess the suitability of the medicine or take any necessary action if the medicine is recalled.

Inspector's evidence

People with wheelchairs could access the pharmacy's services. Team members were observed coming out from behind the dispensing counter to speak to people using mobility scooters. Staff described using written communication for people who were partially deaf and representatives for people who were visually impaired. They checked people's understanding and spoke slowly, clearly and used gestures to assist people whose first language was not English. Three seats were available for people waiting for prescriptions or services.

The pharmacy obtained its medicines and medical devices from licensed wholesalers such as Alliance Healthcare, AAH and Phoenix. Unlicensed medicines were obtained through Alliance. Staff were generally unaware about the processes involved for the EU Falsified Medicines Directive (FMD). The pharmacy was not yet set up to comply with the process and there was no relevant equipment present or guidance information for the team.

Staff checked medicines for expiry every week. Short-dated medicines were identified using stickers. There were no mixed batches or date-expired medicines seen. However, there were some issues seen with the way medicines were stored and managed in both dispensaries. There were loose blisters of medicines seen in the upstairs dispensary and poorly labelled containers present in both dispensaries when medicines were stored outside of their original containers. Some liquid medicines with short stability, when opened and decanted into other containers were not marked with all the necessary details. The last record about the date-checks for medicines that were completed by the team in the care home section was dated April 2019 although the date-checking matrix in the main dispensary had been routinely completed.

Medicines were stored appropriately in the fridges. CDs were stored under safe custody. Keys to the cabinet were maintained in a manner that prevented unauthorised access during the day and overnight. There was also a CD key log in use for this. Drug alerts were received through the company system. The process involved checking for stock and acting as necessary. However, records of this were not routinely kept that could help the team to verify this process.

Medicines brought back by people for disposal were stored within designated containers. There was no list available for the team to readily identify hazardous or cytotoxic medicines. Sharps returned for disposal, were accepted provided they were in sealed bins or alternatively people were referred to the local council for collection. Returned CDs were brought to the attention of the RP, they were segregated in the CD cabinet prior to destruction and relevant details were entered into a CD returns register.

During the dispensing process, tubs and trays were used to hold prescriptions and medicines once

assembled and the team used dispensing audit trails to identify staff involved in various processes. This was through a facility on generated labels as well as a quad stamp on prescriptions. People prescribed higher-risk medicines were identified, counselled and relevant parameters were checked. This included asking about, obtaining and recording relevant information for residents in the care homes and for people receiving compliance aids. Staff were aware of the risks associated with valproates. The pharmacy had completed an audit in the past to identify females at risk and team members explained that conversations would be held with people who could become pregnant. There was also literature available to provide to people.

The team stored prescriptions once they were assembled within an alphabetical retrieval system. Fridge items and CDs (Schedules 2-4) were identified using stickers, PIFs and laminates. Assembled CDs that required safe custody and fridge lines were stored within clear bags, this helped assist in identifying them when they were handed out. Uncollected medicines were removed every five weeks.

In addition to the Essential Services, the pharmacy provided MURs, the NMS, EHC, needle exchange, seasonal flu vaccinations, administered vaccinations for meningitis B, chicken pox and travel vaccinations that included yellow fever as well as supplying medicines for hair retention. The vaccinations and latter service were offered through private Patient Group Directions (PGDs).

When vaccinations were administered, pharmacists worked to defined procedures, SOPs for the services were present, informed consent was obtained, a risk assessment was carried out and relevant paperwork under the PGDs that authorised the pharmacists to provide the services, was signed and readily accessible. The pharmacy was registered with the National Travel Health Network and Centre (NaTHNaC) to administer yellow fever vaccinations. The consultation room was used to provide services and relevant equipment to ensure vaccinations were administered safely was available. This included adrenaline autopens and a sharps bin.

Off-site dispensing: This involved prescriptions being dispensed through the pharmacy's system and details were then transmitted to the dispensing support pharmacy (DSP) in Preston. An accuracy-check of the details submitted by another person did not happen unless staff manually altered any details from the prescription. The prescriptions themselves were held at the pharmacy. Prescriptions for CDs, fridge lines, bulky medicines or antibiotics that required reconstitution were not sent and dispensed prescriptions were sent back from the DSP in two working days. Staff matched bags to prescriptions when received. Dispensed bags were not opened, or items re-checked. If people arrived to collect their medicines before their dispensed prescriptions had returned from DSP, the team dispensed them at the pharmacy. This also happened when items were owing.

Compliance aids: Medicines were supplied to 225 people within compliance aids after the person's suitability for them had been assessed by the RP. The pharmacy ordered prescriptions on behalf of people and once they were received, staff cross-referenced details on them against individual records to help identify any changes or missing items. They were checked with the prescriber and audit trails were maintained to verify this. Patient information leaflets (PILs) were routinely supplied, descriptions of medicines were provided, and all medicines were de-blistered into the compliance aids with none left within their outer packaging. Mid-cycle changes involved them being retrieved and supplying new ones.

Care homes: Medicines were provided to a significant number of care homes with most of them receiving original packs, a few still received medicines inside blisters with the racking system. Most of the care homes requested repeat prescriptions, a duplicate copy of the Medication Administration Record (MAR) detailing the requests was provided to the pharmacy team and prescriptions were checked against this to ensure that all items had been received. A missing items

form was faxed to the care home if any items were outstanding. Interim or mid-cycle items were dispensed at the pharmacy. PILs were routinely supplied. Staff had been approached to provide advice regarding covert administration of medicines to care home residents and they maintained documented details to verify this. A three-way conversation and agreement were required between the pharmacy, care home or representative(s) and the person's GP. Relevant guidelines and resources were used to assess the suitability for this.

Delivery: The pharmacy provided a delivery service and it kept appropriate records about this. CDs and fridge items were highlighted. People's signatures were obtained when they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy with notes left to inform people about the attempt made and medicines were not left unattended.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities that it needs to provide its services safely. And, it uses its equipment in a way that protects people's privacy.

Inspector's evidence

The dispensaries were appropriately equipped with the necessary equipment and facilities. The medical fridges were operating at appropriate temperatures and CD cabinets were legally compliant. The pharmacy was equipped with current versions of reference sources and staff had access to online resources. There were a range of clean, crown-stamped conical measures for liquid medicines and counting triangles. The sinks in the dispensaries, used to reconstitute medicines were clean. The team had access to hot and cold running water as well as antibacterial hand wash. Computer terminals were positioned in a manner that prevented unauthorised access and the team used their own NHS smart cards to access electronic prescriptions. The latter were stored securely overnight.

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.