General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 22-24 West Street, HAVANT, Hampshire, PO9 1PG

Pharmacy reference: 1031752

Type of pharmacy: Community

Date of inspection: 11/07/2019

Pharmacy context

This is a community pharmacy located in the centre of Havant in Hampshire. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews (MURs), the New Medicines Service (NMS), seasonal flu and chicken pox vaccinations. It supplies medicines inside multi-compartment compliance packs to assist people who find it difficult to take their medicines on time. And, it provides medicines to residents in care homes.

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	N/A	N/A	N/A
2. Staff	Standards met	2.1	Good practice	The pharmacy has enough staff to ensure its services are provided safely and effectively, this includes contingency arrangements for unplanned absences
		2.2	Good practice	Pharmacy team members have the appropriate skills, qualifications and competence for their role and the tasks they carry out. Members of the pharmacy team are encouraged to undertake additional responsibilities and this helps to develop their ongoing development and learning
		2.4	Good practice	The pharmacy has adopted a culture of openness, honesty and learning. The company has provided resources to ensure the team's knowledge is kept up to date
		2.5	Good practice	The pharmacist store manager has implemented good practice to motivate the team, he has helped to ensure there are clear lines of communication by using feedback from team members and he has streamlined some services by introducing different ways to cater for some users of the pharmacy's services
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's working practices are safe and effective. Members of the pharmacy team monitor the safety of their services by recording mistakes and learning from them. But, they don't always record all of the details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. The pharmacy encourages people to provide it with feedback and uses this to improve its services. And, it maintains most of its records in accordance with the law. But some details about private prescriptions and unlicensed medicines are missing from its records. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy's dispensing activity occurred from three distinct areas. This included the main dispensary that was situated in the retail area (processing around 100 prescription items/day) and two other dispensaries from where medicines for care homes and multi-compartment compliance packs were assembled. All areas were organised, they were clear of clutter and the workload was manageable.

There were documented standard operating procedures (SOPs) to support the provision of the pharmacy's services. They were reviewed in 2018/19 and the pharmacist store manager had created his own matrix to ensure that the SOPs specific for people's roles were read and signed. It was evident that the staff had read and signed the SOPs, they understood their roles, responsibilities and limitations and knew when to refer to the pharmacist. An incorrect notice for the responsible pharmacist (RP) was initially on display, the second pharmacist explained that the store manager had left the pharmacy for a short period for a training session, this was changed when highlighted. The store manager ensured the correct details were on display when he returned, and this provided people with details of the pharmacist in charge of operational activities, on the day.

Staff used laminated cards to highlight higher-risk medicines and attached Patient Information Forms (PIFs) to each prescription when assembling them. This provided relevant information when checking medicines for accuracy or handing out prescriptions. Prescriptions for care homes and multi-compartment compliance packs were initially labelled to order the stock in, then clinically checked by pharmacists, before being assembled by staff and checked for accuracy. Accuracy Checking Technicians (ACTs) were not involved in any other processes other than the final check, and there was an SOP to cover this process.

Staff recorded their near misses in all the dispensaries. They were collectively reviewed every month by one of the ACTs and the pre-registration pharmacist. The company's Patient Safety Review (PSR) was completed and details were shared with the team. Key learning points were recorded. Action taken in response to errors involved identifying, highlighting and reinforcing to the team about look-alike and sound-alike medicines (LASAs).

Staff also described seeing errors with quantities when dispensing for the care homes as they were in the process of changing their procedures to supply original packs of medicines, selection errors also occurred from manually entering information. To help minimise the latter occurring and to identify mistakes, other staff were involved when processing prescriptions and assembling medicines. In

addition, the ACT had created a wall to highlight and practise safety (see Principle 2). Although near misses were routinely recorded and reviewed, there were missing details. The reason for the errors were not routinely being filled in. This was seen for both the care home dispensing and in the main dispensary.

The pharmacy provided people with information about its complaints procedure. Incidents were handled by the RP and investigated by the store manager. The process was in line with company requirements. Details of previous documented incidents could be viewed on the company system. Feedback about the pharmacy's services was obtained through annual surveys and through the company's cards/surveys. The store manager explained that people had not liked the way they queued previously as there was no system in place, hence a barrier system with customer notices was implemented to help inform people about this.

Staff were trained as dementia friends and could identify signs of concern to safeguard vulnerable people. They had completed the company's e-learning module. Pharmacists, the pre-registration pharmacist and technicians were trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). There were local contact details 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 pharmacy informed people about how their privacy was maintained, and staff were trained on Information Governance and the European General Data Protection Regulation (GDPR) through completing e-learning modules.

Most of the pharmacy's records were maintained in line with statutory requirements. This included records of emergency supplies, a sample of registers seen for controlled drugs (CD) and most of the RP record. For CDs, balances were checked and documented every week. On randomly selecting CDs held in the cabinet (Zomorph, Longtec), their quantities matched entries in corresponding registers. Occasional entries within the RP record were overwritten or out of synchronisation. There were some incorrect prescriber details seen recorded in the electronic register for private prescriptions and not all the required details for unlicensed medicines were being documented.

The maximum and minimum temperatures for the fridge were checked every day and records were maintained to verify that appropriate cold storage of medicines occurred. Staff kept a record of CDs that were returned by people and destroyed by them although there were occasional missing entries of destruction within this. The pharmacy held appropriate professional indemnity insurance arrangements to cover the services provided, this was due for renewal in August 2019.

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. They keep their skills and knowledge up to date by completing regular training. The store manager is proactive and effectively motivates the team. He has introduced new ways for them to communicate more effectively and for the pharmacy to deliver some of its services more easily.

Inspector's evidence

The pharmacy dispensed approximately 12 to 13,000 prescription items every month with 227 people receiving multi-compartment compliance packs and two people with instalment prescriptions. The team also provided medicines to over 47 care homes with capacity for around 368 residents. In addition to the Essential Services, the pharmacy provided MURs, the NMS, seasonal flu and chicken pox vaccinations, Emergency Hormonal Contraception (EHC) and the Pharmacy Urgent Repeat Medicines Service (PURM). The RP explained that there was an expectation to complete 200 MURs by September and this was manageable.

There were usually two pharmacists, one of whom worked up until 2pm and the other was also the store manager. The staffing profile included two pharmacy technicians, two ACT's and six dispensing assistants who worked in the care home section. A pharmacy advisor and a dispensing assistant undertaking accredited training for the NVQ level 3 were responsible for assembling compliance packs and there were five additional pharmacy advisors, a pre-registration pharmacist who had recently finished the exam and a pharmacy student who was due to start as the pharmacy's next pre-registration pharmacist.

The store manager explained that there were currently four members of staff off sick, one was from the care home section and three were from the main dispensary, remaining staff were working additional hours, and this also included the pharmacy student as contingency. The store manager explained that they had asked the latter to work additional hours ahead of her placement as a pre-registration student. There was a bell installed in the other dispensaries to help alert the team if cover was required in the main dispensary. The pharmacy appeared to be managing well with the unplanned absence at the point of inspection and staff were up-to-date with the workload.

Some team members were given additional responsibilities, one of the ACTs was the patient safety champion and the other was the care services customer manager. The latter described liaising with the homes, building relationships, discussing issues and managing the workload. The other ACT had created bespoke briefings with laminated information on one of the back walls in the main dispensary. This helped to highlight and reinforce relevant information about safe practice. This ACT explained that to help avoid repetitive information being provided to the team, she had created this wall after being asked by the store manager to take over the role.

To help motivate the team and to increase morale, the store manager had implemented a 'quotes of the day' system on a door in the main dispensary, where all staff were encouraged to create and list an inspiring quote. Several of the notes were seen along with motivating posters, that were placed strategically in some of the staff areas (that stated for example, 'to stay positive'). The store manager had also implemented bespoke posters on the inside of the consultation room door and he provided

colouring books as well as stickers to help distract children when he vaccinated them for the chicken pox service. He explained that because this was an area where he felt he required assistance, on his own volition, he had researched ways that he could make vaccinating children easier.

The company used in-house surveys to obtain feedback from staff about the pharmacy/company and the store manager explained that an area for improvement identified the reduced amount of communication occurring between management and the team. In response, he brainstormed and looked for ways with the assistant manager that they could combat this, and they subsequently implemented a range of different notice boards upstairs. This provided staff with simplified and relevant information about the pharmacy's performance and other notable areas.

Name badges were worn by staff although certificates for the team's qualifications obtained were not seen, their competence was demonstrated through the inspection. In the absence of the RP, team members knew which activities were permissible. Staff asked relevant questions before they sold over-the-counter (OTC) medicines, queries or uncertainty were run past the RP and team members demonstrated a suitable amount of knowledge of OTC medicines.

To assist with training needs, staff used resources from the company such as e-learning modules, tutor packs and newsletters, they read SOPs and were also signed up to complete training through CPPE. Members of the pharmacy team received formal appraisals every year. Details and updates were regularly conveyed to the team through regular huddles, communication books were used, and staff also verbally informed one another. There was a strong rapport observed between team members and the store manager was described as open to suggestions. Staff felt confident to raise concerns if required, they knew the process to take and who to contact if they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide a professional environment to deliver its services.

Inspector's evidence

The pharmacy premises consisted of a spacious retail area and the main dispensary was smaller but extended into an enclosed back section. Behind this area at the rear, there was a stock room that contained medicines for the care homes. The dispensaries for assembling medicines for the care homes and compliance packs were also located on the ground floor and were not accessible to the public. Both areas were of ample size with plenty of workspace to process and assemble prescriptions. Staff and office areas as well as the driver's hub (see Principle 4) were all situated upstairs. Entry into the two dispensaries and the latter areas could be restricted from key coded access.

The retail space and all three dispensaries were clean, tidy and hygienic. The pharmacy was well presented, suitably bright and appropriately ventilated, temperature control systems helped ensure ambient temperatures were maintained for the storage of medicines.

A signposted consultation room was located inside a corridor that led to the store room, access into this area was restricted, the door was made of clear glass, but a curtain could be drawn across for privacy. It was locked when not in use and the keys were kept on the RP during working hours. Although the room was small, it was of an adequate size for services as there was space for two chairs and for people with wheelchairs. 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

The pharmacy obtains its medicines from reputable sources and stores most of its medicines appropriately. But, it has no containers to store and dispose of some medicines that could be harmful to the environment. The pharmacy generally provides its services safely and effectively. But, team members don't always record information when people receive higher-risk medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

The pharmacy could be accessed at street level through wide front double doors. There was clear space outside the main dispensary/front counter area and wide aisles throughout the store. This helped people with wheelchairs to easily access the pharmacy's services. Two seats were available for people waiting for prescriptions or services. Staff maintained eye contact with people who were partially deaf so that they could lip read, they explained details verbally to people who were visually impaired and described using representatives for people whose first language was not English.

The team signposted people to other organisations from their own local knowledge of the area and could use online information. The pharmacy was healthy living accredited, there was a dedicated section in the pharmacy where people were provided with relevant information about healthier living and staff described completing the framework to become a diabetes focus pharmacy.

The store manager was accredited and trained through company processes to administer chicken pox vaccinations and an appointment system was in operation. He worked to defined procedures, the SOP for the service was present, informed consent was obtained, a risk assessment was carried out and relevant paperwork under the Patient Group Direction (PGD) that authorised this, was signed and readily accessible. The consultation room was used to provide this service and relevant equipment to ensure the vaccination service occurred safely was available. This included adrenaline autopens and a sharps bin.

During the dispensing process, plastic tubs were used to hold prescriptions and medicines once assembled and dispensing audit trails were used to identify staff involved in the various processes. This was through a facility on generated labels as well as a quad stamp on prescriptions. The latter was used by the ACTs to determine whether prescriptions had been clinically checked.

People prescribed higher-risk medicines were identified, counselled and relevant parameters were checked. This included routinely asking about and retaining relevant information for residents in care homes. The team asked about the International Normalised Ratio (INR) level for people prescribed warfarin. Details were seen recorded to verify this but some records for people receiving multi-compartment compliance packs were from 2017/18. The latter were provided this medicine separately to the packs. Staff were aware of the risks associated with valproate. The pharmacy had completed an audit in the past to identify females at risk and relevant people were counselled. 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 2-3) were identified using stickers, PIFs and laminates. Schedule 4 CDs were

not routinely identified. 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 month.

Multi-compartment compliance packs: Medicines were supplied to people within the packs after the person's suitability for them was assessed by the RP, this involved an electronic online system that had recently been implemented. The RP explained that after inputting the relevant information, other options were also provided if packs were unsuitable or deemed unnecessary. The pharmacy ordered prescriptions on behalf of people and when received, details on prescriptions were cross-referenced against individual records to help identify changes/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 within packs were provided and all medicines were de-blistered into packs with none left within their outer packaging. Mid-cycle changes involved trays being retrieved and supplying new packs.

Care homes: Medicines were provided to most of the homes as original packs or a few received them inside blistered packs with the racking system. The latter was being phased out. Once the care homes had requested prescriptions, a duplicate copy of the Medication Administration Record (MAR) detailing the requests was provided and prescriptions were checked against this to ensure all items had been received. A missing items form was faxed to the care home if items were outstanding. Interim or mid-cycle items were dispensed at the pharmacy. The team obtained information about allergies and recorded this on MAR charts. 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/representatives and the person's GP. Relevant guidelines and resources were used to assess the suitability for this.

Delivery: One section of the pharmacy premises upstairs was the central hub for drivers providing deliveries of prescriptions for some of the company's local stores. This was not managed or run by pharmacy staff. The pharmacy provided a delivery service and it kept records to help demonstrate and verify the process. CDs and fridge items were highlighted with separate sheets used to record details of the former. People's signatures were obtained when they were in receipt of their medicines. Failed deliveries were brought back to the branch with notes left to inform people about the attempt made and medicines were not left unattended. Failed deliveries for other local Boots stores were also brought back to this pharmacy if the corresponding pharmacy was closed at the time.

The pharmacy obtained its medicines and medical devices from licensed wholesalers such as Alliance Healthcare, AAH and Phoenix. Unlicensed medicines were obtained through Alliance. Most staff were 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. However, the store manager explained that a new system was due to be implemented by the company soon to help the pharmacy to comply with FMD.

Medicines were stored in an organised manner. They were date-checked for expiry every week and schedules were in place to verify the process. Short-dated medicines were identified using stickers. There were no mixed batches or date-expired medicines seen. Liquid medicines when opened, were marked with the date that this occurred. Medicines requiring cold storage 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 to verify this process. Drug alerts were received through the company system. The process involved checking for stock, acting as necessary and staff passed relevant information to the care homes. A full

audit trail was present to verify the process.

In general, medicines brought back by people for disposal were stored within appropriate receptacles. However, there was no bin available to dispose of hazardous or cytotoxic medicines and no list for the team to readily identify these medicines. People requesting sharps to be disposed of, were referred to another one of the pharmacy's branches who could accept and dispose of sharps. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

All three dispensaries were appropriately equipped with suitable equipment. This included heat sealers for dispensing medicines for the care homes, a range of crown-stamped conical measures for liquid medicines, designated measures for methadone, counting triangles as well as separate triangles for cytotoxic medicines. The sinks in the dispensaries, used to reconstitute medicines were clean. There was hot and cold running water available as well as hand wash present. Fridges were operating at appropriate temperatures for the storage of medicines and CD cabinets were secured in accordance with statutory requirements.

The pharmacy was equipped with current versions of reference sources and staff had access to online resources. There were lockers available for staff to store their personal belongings. Computer terminals were positioned in a manner that prevented unauthorised access and the team used their own NHS smart cards to access electronic prescriptions which were taken home 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.