General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7 Wrawby Street, BRIGG, South Humberside, DN20 8JH

Pharmacy reference: 1032446

Type of pharmacy: Community

Date of inspection: 12/12/2019

Pharmacy context

This is a community pharmacy in the centre of a market town in North Lincolnshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it provides a medicine delivery service to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.8	Good practice	pharmacy team members have a sound knowledge of how to recognise and report safeguarding concerns. And they act to protect the welfare of these people.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services. It keeps all records it must by law. And it manages people's private information with care. The pharmacy advertises how people can feedback about its services. Pharmacy team members act openly and honestly by sharing information when mistakes happen during the dispensing process. And they make changes to their practice to improve patient safety. They have a sound knowledge of how to recognise and report safeguarding concerns. And they act to protect the welfare of these people.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The pharmacy superintendent's team reviewed the SOPs on a two-year rolling rota. Roles and responsibilities of the pharmacy team were set out within SOPs. Training records confirmed that most pharmacy team members had signed to confirm they had read and understood the SOPs relevant to their roles. But there were some gaps in these records. For example, not all team members were identified within SOPs associated with responsible pharmacist (RP) requirements. And at least one team member had not signed some SOPs associated with the sale of over-the-counter medicines. But all pharmacy team members on duty demonstrated a sound knowledge of their roles through discussing and demonstrating how they completed tasks. For example, a healthcare assistant confirmed what tasks could and could not be completed if the RP took absence from the premises. And explained how she would advise a person over the age of 65 to see their GP if they requested an over-the-counter thrush treatment. This was due to the treatment not being licensed for sale to people over the age of 65.

Pharmacy team members in the dispensary were observed working in accordance with SOPs. For example, completing Pharmacist Information Forms (PIFs) at the beginning of the dispensing process. They used these forms to highlight changes to medicine regimens, interactions, higher-risk medicines and eligibility for services to pharmacists. A random check of prescriptions in the pharmacy's retrieval system found PIFs were routinely completed. One prescription stored with an assembled medicine in a tub on the pharmacy workbench was found to contain no PIF.

Pharmacy team members managed their working space well. There was separate areas used to label, assemble and accuracy check medicines. And a small area of the pharmacy's warehouse provided a protected space for completing tasks associated with assembling multi-compartment compliance packs. Pharmacy team members spoke positively about the pharmacy's clinical software programme. The new software had been implemented in Summer 2019. And pharmacy team members demonstrated how it supported safety checks during the dispensing process. For example, they now scanned medicines during the dispensing process. And the system immediately flagged if the medicine scanned did not match that of the medicine on the prescription.

The pharmacy had a near-miss error reporting procedure. This usually involved the pharmacist recording details of the mistakes made after bringing the near miss to the team members attention. The near-miss error record included information to help identify the cause of the mistakes being made. And pharmacy team members explained how there was a focus on applying additional quantity checks to reduce these types of mistakes. The RP explained team members attention had been drawn to

common quantity errors such as assembling a pack of 30 fluoxetine 20mg capsules against a prescription calling for 28. And there had been a positive reduction in these types of mistakes following this increased focus. The pharmacy reported its dispensing incidents through the 'Pharmacy Event and Incident Reporting System' (PIERS). The RP provided evidence of incident reporting. And discussed shared learning following these types of events. For example, team members were checking names, addresses and postcodes for each person individually when prescriptions for different members of one family were handed out.

A dispenser led the patient safety review each month with support from the RP and manager. The review process was generally comprehensive and highlighted trends in mistakes and actions taken to reduce risk. Information from the review was shared with team members routinely. And pharmacy team members confirmed they were able to suggest ideas to help reduce risk during the review process. But the review for October 2019 was minimal due to some missing near-miss error records. The RP explained the team thought the near-miss error record may have been misplaced. And this had meant that the review could not be completed in great detail due to the limited data available. The RP, who was regular pharmacist, had been on leave in October 2019. A discussion took place about some benefits of asking team members to record details of their mistakes on the near-miss error record. This would help to ensure team members knew where the record was kept at all times. Other review templates did identify continual actions being taken to help reduce risk during the dispensing process. And a dispenser highlighted some of these actions. For example, high-risk warning cards were attached to shelving to highlight extra care required when picking 'look-alike and sound-alike' (LASA) medicines.

The pharmacy had a complaints procedure. And its practice leaflet advertised how people could provide feedback to the pharmacy team. The leaflet also included details about how to escalate a concern. A pharmacy team member explained how she would manage a concern and escalate it on to the manager or RP if required. The pharmacy also promoted feedback through an online questionnaire and through its annual 'Community Pharmacy Patient Questionnaire'. Team members explained that the feedback they received was generally very positive.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. Entries in the responsible pharmacist record complied with legal requirements. As did entries in the pharmacy's Prescription Only Medicine (POM) register. The RP explained how the new clinical software programme assisted in making these records as it prompted team members to check the validity of prescriptions during the dispensing process. Records associated with the supply of unlicensed medicines were held in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA). A sample of the controlled drug (CD) register found that it met legal requirements. The pharmacy maintained running balances in the register. And the RP had scheduled dates for ensuring weekly balance checks of the register were completed. A physical balance check of Sevredol 10mg tablets complied with the balance in the register. A CD destruction register for patient returned medicines was kept. And the team entered returns in the register on the date of receipt.

The pharmacy held records containing personal identifiable information in staff only areas of the pharmacy. And information stored in cabinets was secured further by the cabinets being locked. The RP and the pharmacy manager had both moved to the pharmacy in 2019. And they were in the process of reviewing archived records to ensure they were not being stored longer than was required. Pharmacy team members completed mandatory learning relating to data security. The pharmacy had submitted its annual NHS Data Security and Protection (DSP) Toolkit as required. And it displayed a privacy notice. The front area of the dispensary included open-plan work benches. And pharmacy team members demonstrated vigilance when working at these work stations. For example, they removed any

prescription forms from the work bench when leaving the area unattended. The pharmacy team transferred confidential waste to blue bags. Bags were sealed and collected for secure destruction periodically.

The pharmacy had procedures relating to safeguarding vulnerable adults and children. Pharmacy team members completed e-learning on the subject and the RP confirmed she had completed level two learning through the Centre for Pharmacy Postgraduate Education (CPPE). A pharmacy team member explained how she applied her safeguarding learning when managing requests for over the counter medicines. And explained how she would refer any concerns on to the RP. Pharmacy team members shared concerns they had about a person's health and wellbeing with each other. And a team member explained this allowed them to monitor any concerns and report these if necessary. Pharmacy team members spoke with people on their delivery service prior to a delivery being made. And a team member explained how this provided opportunities to check-in with people who rarely visited the pharmacy. A pharmacist had recently shared information about the need to contact the local safeguarding team for some guidance on the RP's day off. Contact telephone numbers to support team members in raising these types of concerns was readily available in a folder in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services and to manage its workload effectively. The pharmacy provides some learning time and engages its team members in regular learning and performance reviews. It promotes ways in which its team members can provide feedback. Pharmacy team members work together well to achieve common goals. And they show how they learn from their mistakes to help improve safety when dispensing medicines.

Inspector's evidence

The pharmacy employed a full-time regular pharmacist, a full-time pharmacy manager (qualified dispenser), another full-time dispenser, three part-time dispensers, a part-time healthcare assistant and a Saturday assistant. The Saturday assistant had recently joined the team as a sales assistant. And she did not complete any tasks associated with pharmacy workload. One dispenser was due to leave the pharmacy to begin management training. And the RP discussed the plans for the other dispensers to expand the time they spent in the dispensary. A company employed driver provided the pharmacy's medication delivery service. The RP confirmed support from the wider relief team was available to help cover annual leave and unplanned leave within the team.

Pharmacy team members confirmed time was available in work to assist them in completing regular learning and reading. But some members of the team preferred to complete this learning at home. Recent learning had included e-learning associated with recognising the signs of sepsis. And reading the 'Professional Standards' monthly newsletter. The pharmacy displayed three key actions from the newsletter each month. And pharmacy team members explained these helped focus them on current risks and learning from case studies. Team members reported feeling supported in their roles. And they explained they were happy to feedback in their performance reviews. Both pharmacy advisors (team members) working on the healthcare counter explained they would like to spend more time in the dispensary to assist with their continual learning. And one team member had recently discussed this in their performance review with the manager. The manager explained how this feedback had been taken onboard and a plan to introduce more time in the dispensary were in place for the New Year.

Pharmacy team members were busy throughout the inspection. And they were observed engaging well with people and providing advice to people purchasing Pharmacy (P) medicines. They also referred people to the RP when further information was required. For example, advice relating to dietary fibre and the use of glycerine suppositories in an infant. A dispenser was observed taking the time to explain details of the pharmacy's 'Free Repeat Prescription Service' (FRPS) to a person. And explained how consent was required to send a text message informing the person that their medication was ready to collect each month. A test message was sent to confirm the pharmacy had the correct details for the person before they left the store. And the person was observed providing positive feedback about his experience to the dispenser. The pharmacy did have some targets set for the services it provided. And the RP explained clearly how she focussed her professional judgement on ensuring she delivered quality services where there was potential for a beneficial outcome for a person. The RP explained her focus in the last few months had been on managing the number of requests for the flu vaccination service. The service was very popular with people and the RP explained how the team's management of its workload helped contribute to her being able to deliver the service efficiently.

Pharmacy team members engaged in discussions relating to workload throughout the day. Feedback from patient safety reviews was delivered on a one-to-one basis. All pharmacy team members were asked to sign the monthly patient safety report. And those spoken to confirmed they were happy to raise any questions they had about the actions required. And they could provide examples of recent actions taken to help reduce risk in the dispensary. For example, recording LASA information on PIFs to prompt additional checks during the dispensing process. The pharmacy had a whistleblowing policy in place. And it displayed details of a confidential helpline for pharmacy team members. Pharmacy team members confirmed they felt supported and were able to provide feedback and suggest ideas for improvement. For example, the recent feedback relating to spending more time in the dispensary to support their continual learning.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was well maintained and it was secure. Pharmacy team members confirmed any maintenance issues were reported to a dedicated support desk. And team members explained these were managed by priority. There were no outstanding maintenance issues reported at the time of inspection. A recent concern with the heating in the warehouse and first-floor level of the premises was reported to be resolved. And the RP explained how tasks relating to the multi-compartment compliance pack service were completed in the dispensary when the heating in the warehouse had not been working. The pharmacy was clean. Floor spaces and workbenches were free from clutter. Antibacterial handwash and towels were available at designated handwashing sinks. The pharmacy had suitable heating and air conditioning arrangements. Lighting throughout the premises was sufficient.

The public area was accessible to people using wheelchairs and pushchairs. There was a clearly sign-posted consultation room. The room was a sufficient size and it was professional in appearance. A filing cabinet in this room was kept securely locked between use as the room was not lockable. The dispensary was a sufficient size for the level of activity undertaken. The pharmacy stored some dispensary sundries and dressings in the warehouse of the premises. It also stored empty and sealed medicine waste receptables in this area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and it ensures its services are fully accessible to people. It obtains its medicines from reputable sources. And it keeps its medicines safe and secure. The pharmacy identifies high-risk medicines to help make sure people taking these medicines have the support they need. It has procedures to support the pharmacy team in delivering its services. But there are some gaps in audit trails associated with the completion of tasks relating to the supply of medicines in multi-compartment compliance packs. This may make it more difficult for the pharmacy to manage a query relating to the service should one arise.

Inspector's evidence

People could access the pharmacy through either a push/pull door or an automatic door at street level. It clearly advertised its opening times and services through window displays and information leaflets close to the healthcare counter. It had a range of service and health information leaflets available to people. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service. And a pharmacy team member was observed doing this, when a medicine was unavailable due to a manufacturing delay. The pharmacy provided designated seating for people waiting for a prescription or service.

Pharmacy team members helped identify people eligible for services by marking this information on the PIF. The RP on duty explained how popular the flu vaccination service was. And she explained how she had taken opportunities to talk to people about their health and wellbeing whilst administering flu vaccinations. The pharmacy had up-to-date and legally valid Patient Group Directions (PGDs) in place for the service. And a recent MHRA drug alert relating to adrenaline autopens was stored in the flu vaccination file. The RP explained she found it helpful to ensure all pharmacists had this type of supportive information available to them when providing the service. An up-to-date protocol for the supply of medicines through the minor ailments service was in place. The RP recognised that it was more difficult to engage people in the Medicines Use Review (MUR) service as people visiting the pharmacy were often in a rush. The pharmacy team members did provide details of this service to people having their medicine delivered. And some people had taken the opportunity to come into the pharmacy and speak with the pharmacist about their medicines. The RP demonstrated how she recorded checks of 'PharmOutcomes' each morning to confirm if there had been any referrals through the new Community Pharmacist Consultation Service (CPCS).

Much of the pharmacy's workload was generated through its FRPS and collection service. And a pharmacy team member explained how audit trails of what each person had ordered on their prescription was used by team members. This helped to ensure prescriptions for people signed up to the FRPS service were complete prior to a person attending to collect their medication. The pharmacy used tubs and baskets throughout the dispensing process. This kept medicines with the correct prescription form. And it helped to identify workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed relevant sections of 'Quad stamps' on prescription forms to identify who had assembled, clinically checked, accuracy checked and handed out the medication. The pharmacy team kept original prescriptions for medicines owing to people. The prescription was used throughout the dispensing

process when the medicine was later supplied. And people receiving their medicines through the pharmacy's delivery service were asked to sign for receipt of their medication.

The pharmacy had systems to identify people on high-risk medicines. And a dispenser identified how high-risk laminate cards were used to prompt monitoring checks and counselling when supplying these medicines. Pharmacy team members recorded monitoring information onto people's medication records when details of monitoring checks were available. A notice in the dispensary prompted team members to complete asthma checks. And a dispenser explained this involved asking some questions when handing out inhalers. For example, a check that a child was using an appropriate spacer device with their inhaler. People were referred to the pharmacist for advice if any further counselling was required. Pharmacy team members demonstrated knowledge of the valproate pregnancy prevention programme (PPP) and understood the importance of ensuring valproate warning cards were issued to people in the high-risk group. And they recognised the need to refer these people on to the RP for additional counselling. The RP provided some further information about the pharmacy's approach to managing high-risk medicines. For example, the completion of audits to ensure these medicines were being appropriately monitored.

The pharmacy had a progress log to help manage the supply of medicines in multi-compartment compliance packs. But pharmacy team members did not always complete this record to help identify completion of each stage of the dispensing process. This was a requirement of the SOP to support staff in managing this service. Every person receiving a multi-compartment compliance pack had a profile sheet in place. And changes to medicine regimens were clearly recorded. It was common practice to start a new sheet to document changes to medicine regimens. And this helped to ensure all information on the sheets was clear and up to date. But not all sheets were completed with start dates and details of who had completed the sheet. A sample of assembled packs contained some dispensing audit trails. But the sample identified that a pharmacist had failed to sign the 'checked by' boxes on one multi-compartment compliance pack. The other three packs inside the bag had been signed. The RP confirmed she would apply her own check of the pack for assurance. And the manager confirmed he would provide feedback to the pharmacist involved, as the team felt something may have caused him to deviate from his standard checking procedure. The pharmacy provided descriptions of medicines inside the packs to help people identify them. And it supplied patient information leaflets with packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The RP had some knowledge of the Falsified Medicines Directive (FMD). And understood the new clinical software programme had been developed to support compliance with FMD in the long run. But pharmacy team members had not completed any specific learning relating to FMD requirements to date. The pharmacy stored medicines in an orderly manner and within their original packaging. A date checking rota was in place and provided confirmation of regular checks being completed. And short-dated medicines were highlighted. Liquid medicines once opened were annotated with the date of opening. This prompted checks to ensure the medicine remained safe and fit to supply to people. A random check of dispensary stock found no out-of-date medicines.

The pharmacy held CDs in a secure cabinet. There was a designated area for storing patient returns, and out-of-date CDs within the cabinet. The pharmacy had two fridges for the purpose of storing medicines. These were clean and well organised. Temperature records confirmed that both fridges were operating between two and eight degrees Celsius. The pharmacy held its assembled CDs and assembled cold chain medicines in clear bags within the secure cabinet and a fridge. This arrangement prompted additional checks of the medicine prior to handout to a person. And bags of assembled CDs contained clear details of the prescriptions 28-day validity period.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It received details of medication recalls and drug alerts electronically. And the RP demonstrated how all alerts were actioned to date. The pharmacy printed copies of alerts and kept these for reference purposes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to help provide assurance that it is in safe working order. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date written reference resources. These included the British National Formulary (BNF) and BNF for Children. Internet access and intranet access provided further reference resources including access to Medicines Complete. The pharmacy had crown stamped measuring cylinders for measuring liquid medicines. The RP explained that replacement cylinders were on order as she had noted some hard water marks on the current cylinders. Cylinders for use with methadone were clearly marked and the pharmacy stored these separate to other equipment. Counting equipment for tablets and capsules was available. This included separate equipment for counting cytotoxic medicines. The pharmacy held equipment to support the seasonal flu vaccination service within the dispensary. For example, adrenaline autopens and a sharps bin. The RP explained how she took this equipment into the consultation room ahead of administering a flu vaccination. The pharmacy's electrical equipment was safety tested. The date of the next scheduled check was April 2020.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Pharmacy team members had working NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection and delivery in drawers behind the prescription reception counter. Personal information on bag labels could not be seen from the public area. It held prescriptions relating to the assembled bags of medicines safely in a prescription retrieval system away from unauthorised access. The pharmacy had cordless telephone handsets. These allowed them to move to the closed area of the dispensary when speaking with people on the phone.

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.