General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 32-36 The Mall, BURY, Lancashire, BL9 0QQ

Pharmacy reference: 1033279

Type of pharmacy: Community

Date of inspection: 14/08/2019

Pharmacy context

This is a community pharmacy in a shopping centre in Bury, Greater Manchester. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including emergency hormonal contraception, medicines use reviews (MURs), flu vaccinations, a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own 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	1.2	Good practice	The pharmacy team members are good at recording, analysing and learning from any errors they make whilst dispensing. And they take steps to make sure the errors are not repeated.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a structured training programme and regular appraisals. The team members tailor their training to help them achieve personal goals.
		2.4	Good practice	The team members work well together and are enthusiastic in their roles. They openly discuss how to improve ways of working. And they regularly talk together about their own mistakes and why they happen. This means they can agree on how to make improvements.
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 has suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It keeps the records it must have by law and keeps people's private information safe. The pharmacy team members have the knowledge necessary to protect the welfare of children and vulnerable adults. And they have some processes and training in place to support them. The pharmacy team members are good at recording, analysing and learning from any errors they make whilst dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy had an open plan retail area which led directly into the dispensary. It had a private consultation room to the side of the pharmacy counter. The responsible pharmacist used a rear bench to do final checks for prescriptions. This allowed her to complete the checks without distractions from the busy pharmacy counter.

The pharmacy had a set of standard operating procedures (SOPs). And these were held in a ring binder. There was an index which made it easy to find a specific SOP. The SOPs included activities including taking in prescriptions, handing out medicines and general dispensing. The team was seen working in accordance with the SOPs. The superintendent pharmacist's office reviewed each SOP every two years. This ensured that they were up to date. The SOPs covering core dispensing had been reviewed in July 2019. The pharmacy defined the roles of pharmacy team members in each procedure. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. Records were available which showed that all team members had read the SOPs that were relevant to their role. The pharmacist countersigned the records when they were happy the team member was competent in following the SOPs. The pharmacy had a daily and weekly audit in place as part of its governance arrangements. Pharmacy team members completed a checklist looking at various aspects of the pharmacy procedures. They tested the fire alarms, checked the responsible pharmacist records and checked controlled drug (CD) security.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The pharmacist or accuracy checking technician typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto a near miss log. The records contained details such as the date of the error and the team members involved. The team members regularly recorded the reasons why the errors had happened. And this helped with their learning and implementing ways to prevent the errors happening again. The logs were analysed each month for any trends and patterns by a team member who was the designated patient safety champion. And the team members discussed the findings in a monthly meeting. The team had recently held a discussion about the importance of making sure the team members did not use previous records stored on the computer system when labelling. For example, the responsible pharmacist demonstrated how a prescription was once labelled using a previous record of levothyroxine 50mcg, when the prescription was for levothyroxine 25mcg. The findings from the analysis were documented into a report which was kept in the dispensary for future reference. The pharmacy had a process to record dispensing errors that had been given out to people. It recorded these incidents electronically. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The report detailed learning and improvement actions following mistakes. The

team had recently talked about ensuring they considered the most appropriate place to affix a dispensing label to a medicine, to prevent any important information being covered up.

The pharmacy had a complaints procedure in place. And it provided details of how people could leave feedback or raise a concern about the pharmacy through leaflets stored near the pharmacy counter. A team member explained how she would manage a complaint and understood how to escalate concerns if required. The pharmacy collected feedback from people through an annual survey. The team members had recently discussed how they could improve their communication with people who felt the service they received, did not meet their expectations.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And they were completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy checked the running balances against physical stock each week. The running balance of Zomorph 10mg was checked, and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy explained how they stored and protected people's information via a poster displayed in the retail area. The team members understood the importance of keeping people’s information secure. And they were all required to complete annual information governance training.

All the team members had completed training on safeguarding vulnerable adults and children via the online training system. And the regular pharmacist had completed additional training via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team did not have any guidance or the details of the local safeguarding teams readily available to them to help them manage and report a potential concern. And so, the team members may be unsure of how to report a concern appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. The team members openly discuss how to improve ways of working. And they regularly talk together about their own mistakes and why they happen. This means they can agree on how to make improvements. The pharmacy is good at supporting its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with a structured training programme and regular appraisals of performance. The team members tailor their training to help achieve personal goals. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection, the team members present were a full-time regular pharmacist, a relief pharmacist, two full-time pharmacy assistants and a pharmacy undergraduate student. The pharmacy also employed a full -time accuracy checking technician and two pharmacy assistants who was not present during the inspection. The relief pharmacist had been recruited to support the regular pharmacist with the dispensing workload during the inspection. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Boots branches to cover planned and unplanned absences. The pharmacists on duty supervised the team members. And they involved the pharmacists in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The team members were able to access the online training system to help them keep their knowledge and skills up to date. They received training modules to complete every month. Many of the modules were mandatory to complete. And the team members received set time during the working day to allow them to complete the modules without interruption. They received around 30 minutes a month. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. Each team member had recently completed training on safeguarding vulnerable adults and children. The pharmacy had an annual performance appraisal process in place. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They were also able to give feedback on how to improve the pharmacy's services. And discuss their personal development. A team member was recently given the responsibility to attend a patient safety conference call.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team members had recently discussed 'look alike and sound alike' (LASA) medicines in the dispensary to prevent them being mixed up when they were dispensing. A list of the medicines was attached to each workstation. And the team members wrote down the name of such medicines on the pharmacist

information form (PIF) to highlight the risk to the team member carrying out the final check. The team members attached 'Select and Speak' stickers to cardboard boxes and placed them on the shelves and drawers in front of LASA medicines. The sticker encouraged pharmacy team members to speak the name of the medicine as the read it. And the box created a physical barrier between the person dispensing and the LASA medicine. Which meant the team members could not access the LASA medicine without coming into contact with the sticker. And, this helped to draw staff attention to the risks of the medicines when dispensing.

The team received a 'professional standards' bulletin each month from the Boots professional standards team. The bulletin often described real life incidents that had occurred in other Boots stores following near miss and dispensing error analysis. The team members discussed the incidents and talked about how they could prevent them happening within their own day-to-day practice. Each team member signed the bulletin to confirm they had read its contents. The team had recently discussed a bulletin which focused on 'safe dispensing for babies and children'. The team decided that they would document on PIF forms, if a prescription was for a baby or a child. This highlighted the risk to the pharmacist and encouraged them to complete thorough check of the directions and dosage when they were checking the prescription.

The team members were able to discuss any professional concerns with the manager or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members were not put under any pressure to achieve the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a professional environment for the health services provided. And, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and portrayed a highly professional image. The benches in the dispensary were kept tidy throughout the inspection. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is easily accessible to people including people using wheelchairs. The pharmacy has robust procedures the team members follow when they dispense medicines into multi-compartmental compliance packs. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. The team members take steps to identify people taking high-risk medicines. And, they provide people with advice to help them take these medicines safely.

Inspector's evidence

The pharmacy had level access from the main shopping centre via a power assisted door. The team members had access to the company internet. Which they used to signpost people requiring a service that the team did not offer. The pharmacy advertised its services and opening hours in the front window. Seating was provided for people waiting for prescriptions. The pharmacy kept a wide range of healthcare related leaflets in the retail area. People could self-select the leaflets and take them away. The pharmacy had a hearing induction loop to help people with a hearing impairment. And, pharmacy team members said they would also use written communication to help people. Pharmacy team members could produce large-print labels to help people with visual impairment.

The team members regularly used various laminated cards that they could use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. They also documented other useful information on PIF forms and kept these with prescriptions. For example, if the person was eligible for a service such as a flu vaccination. The team members signed the dispensing labels to indicate who had dispensed and checked the medication and signed in a quadrant that was printed on the prescription. And so, a robust audit trail of the dispensing process was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Trays were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The trays that contained medicines awaiting a check, were stored in on separate shelves to prevent other medicines falling into them. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy had many of the prescriptions it received dispensed at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as medicine use reviews. The process was carried out in a segregated area, at the rear of the dispensary to prevent any interruptions or distractions. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, it was

accuracy and clinically checked by the pharmacist. A team member inputted the data from the prescription on to the computer system and the data was checked by the pharmacist. It took around three days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then placed on the shelves in the prescription retrieval area, ready for collection.

The pharmacy often dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of its regular patients were prescribed valproate. The team gave appropriate counselling to those people who were identified as meeting the requirements of the programme. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes and living in three local care homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. The packs had dispensing labels attached. And the information to help people visually identify the medicines e.g. blue oval tablet. The team routinely provided patient information leaflets with the packs.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. Every three months, the pharmacy team members checked the expiry dates of its medicines to make sure none had expired. And records were seen. The pharmacy used stickers to highlight stock that was within six months of expiring. No out of date medicines were found after a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive and did not have FMD software or scanners installed. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy used digital thermometers to record fridge temperatures each day. A sample of the records were looked at. And they were within the correct range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team used tweezers and rollers to help them dispense multi-compartmental compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private

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.