General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 3 St Annes Road West, St Annes-on-Sea, LYTHAM ST ANNES, Lancashire, FY8 1SB

**Pharmacy reference:** 1033418

**Type of pharmacy:** Community

**Date of inspection:** 02/05/2019

## Pharmacy context

This is a community pharmacy on a major high street. It is situated in the town centre of Lytham St Annes, on the Fylde coastline near Blackpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also provides a range of services, including seasonal flu vaccinations and emergency hormonal contraception. A number of people receive their medicines inside multi-compartment compliance aids.

## 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 | 1.2 | Good practice | The pharmacy team records and reviews things that go wrong, so that they can learn from them and reduce the chances of the same mistakes happening again. |
| **2. Staff** | Good practice | 2.2 | Good practice | Members of the pharmacy team complete learning modules to help them keep their knowledge up to date. |
| | | 2.4 | Good practice | The pharmacy team discuss learning points from feedback they receive and share the learning with those who are absent. |
| **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 team follows written procedures to help make sure it provides services safely and effectively. Members of the team record and review things that go wrong to help identify learning and reduce the chances of the same mistakes happening again. The pharmacy keeps the records it needs to by law. Staff are given training about the safe handling and storage of data, so that they know how to keep private information safe.

### Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were regularly updated by the company. The dispensary staff had signed to say they had read and accepted the SOPs. However; medicine counter trained staff had not all signed some SOPs relevant to their roles.

A daily checklist was completed to check compliance with a number of professional requirements, including fridge temperature records, expiry date checks, weekly controlled drug (CD) balance checks, and responsible pharmacist (RP) notice.

An internal compliance audit was conducted by the store manager every quarter to check compliance with the company's procedures.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved an incorrect supply of a CD. The pharmacist had investigated the error and action was taken to avoid repetition. This included separating the medicines in the CD cupboard and highlighting particular prescriptions.

Near miss incidents were recorded on a paper log and the records were reviewed monthly by the pharmacist and a dispenser, who had been appointed as the patient safety champion. A near miss analysis tool was used to identify underlying factors such as specific days or times of the day where there were more incidents.

There was evidence of action being taken to manage risks that had been identified, e.g.the pharmacy team had been reminded to clearly mark split packs in dispensary stock. Also, look alike and sound alike medicines were identified and highlighted.

The company shared learning between pharmacies by circulating a professional standards bulletin. Amongst other topics it covered common errors. The pharmacy team would discuss the bulletin in the weekly huddle and staff signed the bulletin to indicate they had read it.

The company had identified a number of common errors that had occurred in other branches and the medicines involved had been designated as 'safer six' drugs. Warning stickers were attached to the shelves where these medicines were stored to highlight the risks.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore a standard uniform and had badges

identifying their name and role. The responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure and it was described in the practice leaflet. It advised customers how to make direct contact with the pharmacy or with the company's head office. Complaints were recorded to be followed up by the store manager or head office.

A current certificate of professional indemnity insurance was provided by the company prior to inspection.

Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. The balance of two CDs were checked and both found to be accurate. Patient returned CDs were recorded in a separate register.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team received annual IG training and had signed confidentiality agreements in their contracts. When questioned, the dispenser was able to correctly describe what information was considered confidential and how it was segregated to be removed and destroyed. A privacy notice was not on display; the pharmacy team said one had been displayed but had been moved by the store manager and they were unaware where it was.

Safeguarding procedures were included in the SOPs. The pharmacist said she had completed the level 2 safeguarding training and the pharmacy team also had safeguarding training. Contact details of the local safeguarding board were on display in the dispensary. The dispenser said she would initially report any concerns to the pharmacist on duty.

## Principle 2 - Staffing ✔ Good practice

### Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. The pharmacy team complete learning modules to help them keep their knowledge up to date. They get regular feedback from their manager and discuss how they can improve.

### Inspector's evidence

The pharmacy team included two pharmacists, a pharmacy technician, who was also the store manager, and three dispensers. A number of other staff were also employed in the retail area, two of whom were trained as medicine counter assistants (MCAs). All members of the team had completed the necessary training for their roles.

The normal staffing level was a pharmacist, two dispensary staff, and the two trained MCAs - who could help to cover the medicines counter when it was busy.

The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could also be requested but the pharmacy team said this was rarely necessary.

The company provided the pharmacy team with a structured e-learning training programme. And the training topics appeared relevant to the services provided and those completing the e-learning. Training records were kept showing that ongoing training was up to date. Staff were allowed learning time to complete training.

The dispenser was seen to sell a pharmacy only medicine using the WWHAM questioning technique. She could also provide an example of how co-codamol sales she felt were inappropriate were refused and referred to the pharmacist if needed.

The pharmacist said she felt able to exercise her professional judgement and this was respected by the pharmacy team and store manager.

The dispenser said she received a good level of support from the pharmacy team and felt able to ask for further help if she needed it.

Appraisals were conducted annually by the store manager. A dispenser said she would complete a pre-appraisal form before the manager discussed her performance, training requirements and areas for improvement. She felt that the appraisal process was a good chance to have a discussion about her work.

The staff held weekly huddles about issues that had arisen, including when there were errors or complaints. A communications diary was used to record important information so that it could be shared with staff who were not present.

Staff were aware of the whistleblowing policy and said that they would be comfortable escalating any concerns to the head office.

There were service-based targets set by the company for MURs and NMS. The pharmacist said she did not feel under pressure to achieve these.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to allow private conversations.

### Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink and washing facilities were available within the dispensary. Access was restricted by the position of the counter.

The temperature was controlled in the pharmacy by the use of air conditioning units. Lighting was sufficient. The staff had access to a canteen and WC facilities.

A consultation room was available. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are accessible to most people.  And they are suitably managed to help make sure that they are provided safely. The pharmacy gets its medicines from appropriate sources, manages them safely and carries out regular checks to help make sure that all its medicines are in good condition.

### Inspector's evidence

Access to the pharmacy was level via an automatic door and was suitable for wheelchair users. The consultation room was wheelchair friendly and a portable hearing loop was available. The PMR system was capable of producing large print font.

Pharmacy practice leaflets gave information about the services offered. There was also information available on the company's website. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using signposting information.

The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics.

There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of the patient.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. The driver used an electronic device to obtain a signature from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a separate signature obtained on receipt.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using a numerical retrieval system. Prescription forms were retained, and laminates were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 CDs were highlighted so that staff could check prescription validity at the time of supply. However; schedule 4 CDs were present that had not been highlighted. Which means there is a risk that they could be supplied after the prescription had expired.

Laminates were available to indicate when high risk medicines (such as warfarin, lithium and

methotrexate) were present. But they were not always used and some prescriptions were present without them included. So the pharmacy team may not always be aware when they are being handed out in order to check that the supply remains suitable.

Fridge items awaiting collection were stored in clear bags so that the patient and the pharmacist could confirm the correct item was dispensed as an additional checking step. Staff said they would show the patient their insulin to ensure it was correct.

Substance misuse supplies were assembled a week in advance and stored in the CD cupboard and clearly segregated between each patient using dividers. The pharmacist said she had completed the CPPE substance misuse training programme and when questioned was able to correctly describe the procedure if the patient had not collected their prescription for three days.

The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she had completed an audit, but there were currently no patients that met the risk criteria.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for all compliance aids patients containing details of current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance packs included medication descriptions, dispensing check audit trail and patient information leaflets (PILs).

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The pharmacist said that consent was not obtained from the patient for the prescription to be dispensed by another contractor. So people may not always be aware that their information is being shared.

Medicines were obtained from licensed wholesalers, with unlicensed medicines source via a special's manufacturer.

The pharmacy was not yet completing the safety checks needed for the Falsified Medicines Directive (FMD), which is now a legal requirement. The pharmacy team were aware of the requirements but were not aware of what steps the company were taking to implement this.

Stock was date checked on a three month rotating cycle. A date checking matrix was signed by staff as a record of what had been checked and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock.

There was a clean medicines fridge with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed that temperatures had been within the required range for the last three months.

Patient returned medication was segregated from current stock in designated bins for storing waste medicines located away from the dispensary.

Drug alerts were received electronically by email. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

### Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in October 2018.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for CDs. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

## 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. |