General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 18 High Street, OAKHAM, Leicestershire, LE15 6AL

Pharmacy reference: 1034230

Type of pharmacy: Community

Date of inspection: 29/05/2019

Pharmacy context

The pharmacy was situated on the high street in the town centre. It dispenses NHS and private prescriptions and sells over-the-counter medicines. In addition to the standard NHS services it also provides services under private patient group directions including a private travel clinic.

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 has good processes for learning from mistakes and uses these to improve the safety and quality of its services.
		1.3	Good practice	The pharmacy team members have defined roles and accountability. They share responsibility for making sure that the services they provide are safe.
2. Staff	Standards met	2.5	Good practice	The pharmacy team members are comfortable about providing feedback and are committed to improving 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

The pharmacy identifies and manages most of the risks associated with the provision of its services. It has good processes for learning from mistakes and uses these to improve the safety and quality of its services. The pharmacy team members have defined roles and accountability. They share responsibility for making sure that the services they provide are safe. The pharmacy keeps the records required to make sure that medicines are supplied safely and legally. The pharmacy adequately manages people's personal information. It asks its customers for their views and knows how to protect vulnerable people.

Inspector's evidence

The responsible pharmacist (RP) notice showing the pharmacist in charge of the pharmacy was clearly displayed. As part of the dispensing of a prescription a pharmacist's information form, referred to as a PIF, was completed. Staff explained that the PIF was used to highlight key risks to the pharmacist such as new medicines, change of dose or strength. Prescriptions checked had a PIF attached and had a range of information recorded to allow the team to give appropriate advice to people collecting medicines.

The pharmacy had a set of up-to-date standard operating procedures (SOPs), signed by staff, which reflected how the pharmacy operated. Staff were observed to follow the SOPs with dispensed and checked by boxes on the medicine label and the quad box on the prescription signed; the PIF was completed and controlled drugs (CDs) running balances were checked weekly.

A member of the team explained the principle behind the look alike sound alike (LASA) process. There were laminates attached to the computers listing the medicines most likely to picked by mistake. She explained that as part of the process the name of the medicine should be written on the PIF. PIFs seen showed the process was being followed.

A weekly clinical governance check was carried out. This ensured the pharmacy was reviewing risks such as whether SOPs were being followed; legal records were up to date; medicines were stored appropriately, and incidents were reviewed.

The pharmacy also had a number of prompt cards which were placed with dispensed prescriptions. The dispenser explained how they were used. Cards said if there was a CD or fridge line or to refer a person collecting a prescription to the pharmacist for counselling. In addition, there were cards for higher-risk medicines such as lithium, methotrexate or warfarin, with questions the person handing out the medicine should ask on the back. Dispensed prescriptions seen had the required prompt cards attached.

The dispenser understood how to sell a medicine safely. But she didn't explain the two protocols that Boots use depending on whether a medicine is asked for by name or by symptom. She had a satisfactory product knowledge and could give suitable advice. She knew that CDs had a 28 day validity and could recall most, but not all, of the CDs that were not kept in the CD cupboard. When the inspector checked the dispensed prescriptions waiting collection CDs were highlighted and had prompt cards.

The pharmacy had a colour-coded system for all prescriptions waiting collection. Each week the team texted all the people who hadn't collected their medicines for a week or more. If they hadn't collected after five weeks the staff tried to contact them and then took the medicine off the shelf and returned the prescription back to the NHS spine. The pharmacy kept dispensed CDs and insulin in clear bags to allow the medicines to be easily checked before they were supplied.

The pharmacy kept records of near misses, errors and incidents. Near misses were discussed at the time they were found with the member of staff responsible. A record was then made in the near miss log. The near miss log showed that the pharmacy had made a significantly larger number of near misses than usual for May. There had also been more dispensing errors than normal. It was good to see that the pharmacy team had been recording them so that there was the opportunity to learn from them. The pharmacist explained that the increase had been caused by a member of staff leaving which had put extra pressure on the team. And that the pharmacist had started just over a month ago. A new member of staff was starting soon, and the pharmacy had had some double pharmacist cover.

At the end of the month a patient safety review was carried out by a dispenser. She explained how she had asked to take on this role. April's review was a comprehensive document. It had highlighted a range of actions which included writing the name of the LASA on PIF; PIFs seen showed this was now routinely done. The dispenser said that they had a monthly huddle to discuss the issues.

The pharmacist had a little plastic folder attached to the near miss log for the team to put ideas or issues in as they found them so that they wouldn't be forgotten. In the folder there was an unmarked original pack with one tablet removed; there were also PIFs highlighting missed actions, for example not recording the date the owing was collected.

The pharmacy provided a range of travel services. This included malaria prophylaxis and a range of vaccinations including yellow fever. The PGDs were in date. On the day of inspection the services were being provided by the second pharmacist who had not brought his record of training and competence with him.

The pharmacy had a contract with NHS England to provide emergency hormonal contraception via a patient group direction. However, the new regular pharmacist had not yet completed the training so at the time of the inspection the service was not being provided.

The pharmacy received a letter from the superintendent highlighting changes in procedures and learning points across the stores. The latest letter had been signed by staff to show they had read it. An audit trail was created using dispensed by and checked by boxes and the use of the quad box on the prescription. The final check was carried out by the RP.

The pharmacy was a Healthy Living Pharmacy, the pharmacy team said that there wasn't a display of advice in the public area. The store manager, who wasn't present on the day of inspection. subsequently indicated by email that the pharmacy did had an advice board in the middle of the store.

The latest patient satisfaction survey from March 2019 was on the website NHS UK. 89% of people had rated the pharmacy as excellent or very good. There was a complaints procedure in place. There was a pharmacy leaflet available which gave a range of external organisations that people could contact. There were contact details for Boots customer care service on the back of till receipts.

Public liability and professional indemnity insurance were in place. Records to support the safe and effective delivery of pharmacy services were maintained. These included the RP record book, private prescription records and the controlled drug register. CD running balances were checked on a weekly

basis. A random check of the recorded running balance of a CD reconciled with the actual stock in the CD cabinet. Dispensed CDs in the cupboard waiting collection were all in date. They all had a label which showed the date by which the medicine needed to be supplied. Out-of-date and patient-returned CDs were clearly marked and separated. There was a record of patient returns which included schedule 3 CDs.

Most computer terminals were positioned so that they couldn't be seen by people in the retail area. The computer on the counter didn't have a privacy shield and the pharmacist said that people could lean over to see it. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was bagged and sent away for secure destruction. There was an information governance protocol in place. The pharmacy team were aware of the safeguarding procedure; the pharmacist had completed the CPPE training. Local contact details were available if the pharmacy needed to raise any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

On the day of inspection, the pharmacy had sufficient numbers of suitably qualified staff to safely provide pharmacy services. However, the team said that one of the reasons for a recent increase in mistakes was due to staff shortages because a member of staff had left. The team members worked well together. They are comfortable about providing feedback and are committed to improving the pharmacy's services. There is a work culture of openness and honesty. The pharmacy team members have access to a range of training resources with which to improve their skills. But there wasn't always sufficient time at work to study them.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. During inspection the pharmacy had two pharmacists; one trainee pharmacy technician, and three trained dispensers. Staff were able to manage the workload within the pharmacy when fully staffed but a member of the team leaving had led to an increase in mistakes.

Staff said that they had appraisals every three months with an annual review to set objectives. They had an input into the process. Staff said that the manager was easy to speak to and they were comfortable in giving suggestions to improve the service and could raise concerns if necessary.

The pharmacy team members worked well together and actively engaged with the inspection process. They wanted to improve the service and had taken on responsibility for the monthly review of near misses. Staff were up to date with changes such as electronic prescriptions for CDs and the changes in the legal requirements for gabapentin and pregabalin.

There was a range of training for all staff on the e-Learning site; staff had dedicated time to complete e-Learning. There were also monthly 30 minute tutors, but staff said that they didn't always have time to complete these. One of the dispensers was training to be a pharmacy technician. She said that she had asked to study the course. She had an hour a week but completed most of her training at home. The pharmacist said that she had done some informal training around how long a prescription was valid for by doing a quiz. Although targets for services were set the pharmacist said they didn't compromise customer service or her professional integrity.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. It protects people’s confidentiality. The premises are secure from unauthorised access when open and when closed.

Inspector's evidence

The dispensary was quite small for the number of prescriptions dispensed with a limited dispensing bench available for the assembly of medicines. But there were also additional separate rooms for the assembly of multi-compartment compliance aids and dispensing of medicines for care homes which meant that overall there was sufficient space. The dispensary was clean and tidy; there was a sink with hot and cold water.

The pharmacy had air conditioning to provide an appropriate temperature for the storage of medicines; lighting was sufficient. A small size basic consultation room was available to ensure that people could have confidential conversations with pharmacy staff. During inspection it was used for travel vaccination services.

Computer screens were mainly set back from and face away from the counter. Access to electronic patient medication records (PMR) was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. The pharmacy is good at providing people with the advice and support they need to help them use their medicines safely. The pharmacy obtains its medicines and medical devices from reputable sources. The pharmacy manages and stores its stock medicines well. Stock is stored at the right temperature in suitable containers. There is a clear and robust time period for supplying liquid medicines once they have been opened. The pharmacy takes the right actions if any medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy was in a row of shops in the town centre. There was an automatic door which provided easy access for people in a wheelchair or those with a physical disability. There were signs advertising the opening hours and services provided.

Work was prioritised based on whether the prescription was for a person who was waiting or coming back. The pharmacy used a dispensing audit trail which included the use of dispensed by and checked by boxes and a quad stamp on the prescription to show who had been involved in dispensing the prescription. The pharmacy used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of medicines.

The pharmacist said that she gave advice to people using the pharmacy on a range of matters. This included dose changes, change in formulations; and inhaler technique. She spoke to people taking higher-risk medicines such as methotrexate lithium and warfarin. PMR records seen had INRs recorded. She checked that people taking methotrexate had regular blood tests. She had a good range of clinical knowledge including checking that people on NSAIDs had omeprazole and people on carbimazole were aware of signs of infection. The pharmacist said that she heard staff asking questions as required by the cards. She said that the pharmacy didn't have any people taking sodium valproate in the at-risk group. She was aware of the advice that she should give. However, she didn't have the latest patient information leaflets. She said she would contact the manufacturer to obtain them. The pharmacist understood signposting people to other healthcare providers and knew where to access local services such as EHC.

Records showed that medicines requiring cold storage were kept in a fridge between 2 and 8 degrees Celsius. The current temperature of the fridge was within range. Medicines were stored on shelves tidily and in original containers. Date checking was carried out on a three month rotation; stickers were used to highlight short-dated medicines. Out-of-date medicines were put in yellow waste bins. Bottles that didn't have a specific use by date once open had stickers which showed the date of opening and also a use by date of six months. This was good practice.

Each person who received their medicine in a compliance aid had an individual record which listed their medicines and when they should be taken. Prescriptions were checked with the record and any differences were raised with the surgery. The surgery usually made the pharmacy aware of any changes but if not, the pharmacy contacted the surgery to confirm the change. The record seen had been changed when a medicine was changed to make a clear easy-to-read record. The medicine administration chart (MAR) charts recorded the shape and colour of the medicine to allow easy

identification. The two compliance aids checked didn't have patient information leaflets (PILs). The dispenser said that the aim was to send them each month. The pharmacy supplied medicines to care homes; it had recently changed to providing medicines in original packs. The dispenser explained how this process had been managed smoothly with homes happy with the new system.

CDs were stored safely. Access to the CD cabinet was managed appropriately. The pharmacy delivered medicines to people. The person who received the medicine signed for the medicine. The pharmacy only had records for CD deliveries but records for other medicines would be available from the hub if required.

Only recognised wholesalers are used for the supply of medicines.The pharmacy had not yet implemented Falsified Medicines Directive requirements and wasn't aware of when it would be implemented in the store. The pharmacy team were aware of the procedure for drug alerts. A record was created and signed to provide a complete audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers. It adequately maintains the equipment and facilities that it uses.

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids; separate measures were used for CDs. The pharmacy also had tablet and capsule counters.The pharmacy had a range of up-to-date reference sources.Electrical appliance testing was next due in October 2019. Confidential patient information was stored securely. Confidential waste paper was collected in a confidential waste bag and taken away for destruction.

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.