General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 26 Market Place, BOSTON, Lincolnshire, PE21 6EH

Pharmacy reference: 1034241

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

This is a community pharmacy in the centre of a busy market town in Lincolnshire. The pharmacy is part of a larger health and beauty store. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy also offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. The pharmacy also supplies medicines to care homes across Lincolnshire. And it delivers medicines 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	1.2	Good practice	The pharmacy promotes an open and honest culture of continual learning amongst its team by engaging pharmacy team members in comprehensive safety reviews. These reviews demonstrate how pharmacy team members continually reflect and act to reduce risks during the dispensing process. And they regularly measure the effectiveness of the actions they implement.
2. Staff	Good practice	2.2	Good practice	The pharmacy provides access to a good selection of training topics with protected learning time for the team. And it engages its team members in regular learning and performance reviews.
		2.4	Good practice	Pharmacy team members are committed to working in an environment of openness and transparency. And they work together to achieve common goals.
		2.5	Good practice	The pharmacy team members feel comfortable sharing their ideas. And the pharmacy uses the feedback it receives from pharmacy team members to inform the safe management of its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy has robust management processes in place to help identify and manage the risks associated with providing its services. It undertakes its high-risk workload in controlled environments to avoid the risk of distraction.
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 promotes an open and honest culture of continual learning amongst its team by engaging pharmacy team members in comprehensive safety reviews. These reviews demonstrate how pharmacy team members continually reflect and act to reduce risks during the dispensing process. And they regularly measure the effectiveness of the actions they implement. The pharmacy keeps people's private information secure. And it responds appropriately to feedback it receives about its services. The pharmacy provides all its team members with training relating to protecting the safety and wellbeing of vulnerable people. And it has clear processes in place for reporting these types of concerns. The pharmacy generally keeps all records it must by law. But some minor gaps in these records occasionally result in inaccurate audit trails.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. 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. Pharmacy team members explained how updated and new SOPs were brought to their attention by a manager. They read and signed the SOP and discussed its contents prior to a pharmacist assessing their competence and signing the training as complete. A sample of training records confirmed that members of the team had completed training associated with their roles. Pharmacy team members on duty were seen working in accordance with dispensary SOPs. A member of the team clearly explained the tasks which could not take place if the responsible pharmacist (RP) took absence from the premises. And the team was observed communicating to people that prescriptions could not be handed out during the pharmacist's lunch break. A prominent notice on the door and at the healthcare counter provided people with advanced notice of the pharmacist's planned lunch break. Another team member demonstrated how pharmacists recorded the clinical check of a prescription. There were two accuracy checking pharmacy technicians (ACTs) in the team. And the ACTs discussed how they held additional accountabilities such as leading patient safety reviews. And how they applied their professional judgement went undertaking the accuracy check of a medicine. For example, referring a prescription to a pharmacist if there was no recorded clinical check. And raising queries about doses and medicine regimens if concerns arose.

The pharmacy had an up-to-date business continuity plan in place. Managers undertook daily, weekly and monthly clinical governance checks of the pharmacy environment. This helped provide ongoing assurance that the pharmacy was operating safely and effectively. It had three dispensaries in operation. The main dispensary was situated close to the healthcare counter. Pharmacy team members working in this dispensary managed acute workload and some repeat prescriptions. A small dispensary at the back of the premises was dedicated to managing workload associated with the pharmacy's 'free repeat prescription service' (FRPS). The third dispensary was split into two working areas. One for the management of care home services and the second area for the management of the multi-compartmental compliance pack service.

The pharmacy had identified the care home and multi-compartmental compliance pack service as high-risk. As such both dispensaries presented a red tray to a pharmacist twice a day. The tray contained

information relating to urgent matters such as out-of-stock medicines and changes to medicine regimens. The pharmacist was required to check the contents of the tray and completed an audit sheet to confirm these checks and any outstanding actions had been completed. 'Pharmacist information Forms' (PIFs) were used to communicate key messages to pharmacists, such as changes to medicine regimens, interactions and eligibility for services. The team retained PIFs with prescription forms to inform counselling required when handing-out medicines. A random check of the prescription retrieval filing system found PIFs attached to all selected prescriptions. PIFs were completed in accordance with details within the SOPs. And extended PIFs were in use for the care home and multi-compartmental compliance pack services which allowed more detailed information to be recorded.

There was a near-miss error reporting procedure in place. And pharmacy team members identified how they discussed their own mistakes with a pharmacist or ACT. Pharmacy team members contributed to recording mistakes and the near-miss error reporting form prompted reflection of the mistake, such as contributory factors. Information recorded in this section of the record varied in quality, some team members reflected particularly well on the causes of their mistakes. And this recorded reflection aided the review process by helping to identify trends in contributory factors. The pharmacy recorded dispensing incidents electronically through the internal 'Pharmacy Incident and Event Reporting System' (PIERS). Evidence of reporting was available. And pharmacy team members were knowledgeable about the actions taken to reduce risk following an incident.

The pharmacy's ACTs led monthly patient safety reviews with members of the pharmacy team. The care home dispensary team's review focussed on reviewing and learning from near-miss errors and patient safety events related to both the care home and multi-compartmental compliance pack service. And the main dispensary team's review focussed on the acute and managed dispensing services. Pharmacy team members demonstrated how they applied learning from the review. For example, PIFs were highlighted with details of look alike and sound alike (LASA) medicines. This prompted additional checks during the dispensing process. Pharmacy team members were also highlighting key information on prescription forms, such as unusual quantities. There was a clear reflection process following the review with key actions being measured for their effectiveness the following month. And any repeated action points were clearly identified and brought to the attention of team members as high priority areas of focus.

The pharmacy advertised its complaints procedure clearly within its practice leaflet. And pharmacy team members could explain how they would manage feedback or a complaint. A pharmacy team member discussed the escalation process for concerns if people were not happy with the response provided. The pharmacy promoted feedback through making 'Community Pharmacy Patient Questionnaires' available to people. And it advertised an online questionnaire. But the opportunity to promote the online questionnaire was not always taken.

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 RP record followed legal requirements. A sample of the controlled drug (CD) register found that it met legal requirements. The pharmacy kept running balances in the register. Balance checks of the register against physical stock took place weekly. A physical balance check of Sevredol 10mg tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. The team entered returns in the register on the date of receipt. The pharmacy held the Prescription Only Medicine (POM) register electronically. Records generally complied with legal requirements. But there were a couple of private prescription entries found which contained inaccurate prescribing dates. And one dispensed private prescription did not include the date of prescribing. A discussion took place about the requirement to ensure all legally required information was present on a prescription prior to dispensing beginning. The

pharmacy completed full audit trails on certificates of conformity for unlicensed medicines as per the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA)

The pharmacy held records containing personal identifiable information in staff only areas of the pharmacy. Lockable storage in the pharmacy's warehouse was utilised for storing some archived records. The team completed annual information governance training. And it had completed additional learning following the introduction of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS data security and protection (DSP) toolkit as required. Pharmacy team members put confidential waste in designated holding areas in the dispensaries prior to transferring it into blue bags which were sealed and sent for secure destruction periodically.

All pharmacy team members completed mandatory safeguarding training. And pharmacy professionals had completed level two learning through the Centre for Pharmacy Postgraduate Education (CPPE). Members of the team spoken to about safeguarding were able to identify what safeguarding a vulnerable person meant to them. And could provide hypothetical scenarios of how they would recognise and report a concern. The pharmacy had up-to-date procedures in place for safeguarding vulnerable people. And contact details for local safeguarding agencies were advertised to pharmacy team members.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services and to manage its workload effectively. The pharmacy provides protected learning time and engages its team members in regular learning and performance reviews. It also promotes ways in which its team members can provide feedback. And it uses the feedback it receives from pharmacy team members to inform the safe management of its services. Pharmacy team members are committed to working in an environment of openness and transparency. And they work together to achieve common goals. They contribute to regular shared learning exercises relating to risk management and safety.

Inspector's evidence

The pharmacy was busy throughout the inspection. But there was enough staff on duty to support the workload carried out. And managed workload was up to date. The pharmacy's full-time regular pharmacist had left the pharmacy within the last month due to retirement. The RP on duty was providing some regular support to the team along with other company employed relief pharmacists. A regular pharmacist worked one day a week in the pharmacy and completed the support visits to care homes. Another store-based pharmacist worked one in four Sundays. Two pharmacists were on duty three days each week. In total the pharmacy employed two accuracy checking technicians, a pharmacy technician, 15 dispensers (pharmacy advisors) and two healthcare advisors. Both the pharmacy manager and assistant manager were also qualified pharmacy advisors. The prescription delivery service was provided by company employed drivers. There was some ongoing changes to the staffing structure due to regular profile reviews and staff turnover. Some pharmacy team members identified how busy holiday periods did increase workload. But annual leave was planned well in advance to ensure staffing levels remained adequate during these periods.

Pharmacy team members were encouraged to complete regular learning and reading. This included the completion of regular 'Tutor' modules on a range of healthcare topics and regular e-learning. The pharmacy's superintendent pharmacist's office provided regular newsletters which prompted reading and discussion about patient safety. And pharmacy team members discussed recent topics covered by these newsletters. Each member of the pharmacy team received a small amount of protected learning time each week. Pharmacy team members received regular verbal feedback and scheduled learning and performance reviews with their managers. And those spoken to about the appraisal process confirmed they felt able to feedback during their review. One member of the care home team had benefitted from some shadowed working arrangements prior to progressing in her role within the team.

The pharmacy was busy throughout the inspection. Pharmacy team members worked well together to prioritise customer service during particularly busy periods. The pharmacy did have some targets which it measured through scorecards. The RP explained that patient safety was her number one priority and she discussed how she applied her professional judgement when managing the delivery of services. Pharmacy team members supported pharmacists by identifying people eligible for services by recording this information on the PIF.

Pharmacy team members engaged in daily briefings to help organise workload, highlight areas of priority and discuss any learning from the previous day. ACTs led the patient safety reviews with input

from regular pharmacists and the management team. The care home team held the review as a structured team meeting. Reviews in the main dispensary and with the FRPS dispenser took the form of smaller discussions and one-to-one feedback due to shift patterns and the need to cover the public facing dispensing services. Pharmacy team members were confident when describing learning following these reviews. For example, one pharmacy advisor explained how they used a notebook to reflect on the learning and their own individual mistakes. The team member explained this helped to reduce the risk of similar mistakes occurring.

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 pharmacy had implemented coloured strips on tubs in the dispensary. This allowed the team to further manage workload priority during the dispensing process. For example, red bands indicated acute prescriptions requiring immediate attention. The pharmacy team had fed back the need for an additional fridge to support the seasonal flu vaccination service. And this additional fridge was sourced and placed in the consultation room. The RP explained how it would help with storage arrangements but also reduce the risk of disturbing dispensing processes by not needing to access the main dispensary fridge during this busy period.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. People can access the pharmacy's private consultation facilities to speak to a member of the team in confidence.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was fitted with wide-spaced aisles which allowed easy access for people using wheelchairs and pushchairs. There was a private consultation room, and this was clearly sign-posted. The RP was observed moving from the healthcare counter to the room with a person who required a confidential consultation. The room was locked between use to prevent the risk of unauthorised access.

The dispensaries were a suitable size for the level of activity carried out in each. The main dispensary and care home dispensary had air conditioning and a fan was available to assist with ventilation in the FRPS dispensary. Lighting in all work areas was bright. Work benches across all dispensaries were free from clutter. Shelving in each dispensary helped manage space by being utilised to hold assembled medicines in tubs and trays. The pharmacy used secure gated units in the warehouse to store some archived information and medical waste.

Pharmacy team members reported maintenance issues to a designated help-desk. There were no outstanding maintenance issues found during the inspection. The pharmacy was clean and organised with no slip or trip hazards evident. Antibacterial soap and paper towels were available close to sinks in the dispensary and at other designated hand washing sinks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. The pharmacy team demonstrates how it manages workload effectively. And the pharmacy has robust management processes to help identify and manage the risks associated with providing its services. It undertakes its high-risk workload in controlled environments to avoid the risk of distraction. The pharmacy obtains its medicines from reputable sources. And it stores and manages them appropriately to help make sure they are safe to use. It has systems in place to provide assurance that its medicines are fit for purpose.

Inspector's evidence

The store was accessed from street level through an automatic door and push/pull doors. The pharmacy was located at the back of the store and was advertised well from the entrance. It displayed details of its opening times and services. Health promotion displays at the healthcare counter were prominent. For example, the pharmacy was advertising treatments for insect bites and seasonal allergies. There was also information available to support mental health campaigns, including a guide to children's mental health and wellbeing. Pharmacy team members were aware of sign-posting arrangements in the event they could not provide a service or a medicine. Designated seating was available for people waiting for prescriptions or pharmacy services.

The pharmacy team members identified high-risk medicines and highlighted these prescriptions through the use of bright laminated cards. The cards included details of monitoring checks and counselling required when supplying these medicines. A pharmacy team member was observed informing the RP of a person's blood monitoring results and entering details of the monitoring check on the patient medication record. Both the care home and multi-compartmental compliance pack teams had processes in place to ensure people taking high-risk medicines were regularly monitored. A pharmacy team member demonstrated the requirement to identify people taking valproate preparations. And people in the high-risk group were suitably counselled. Valproate warning cards were readily available to issue to people, in accordance with the requirements of the valproate pregnancy prevention programme (PPP).

Two pharmacy team members managed the supply of medicines in multi-compartmental compliance packs. They were supported by other team members throughout the dispensing process. For example, an ACT completed accuracy checks associated with the service. The team used carbon copied communication sheets to record details of queries and steps taken to resolve them. A pharmacy team member demonstrated a complex change to medication which had resulted in a number of queries being made with both carers and prescribers. The team had used the communication sheets effectively to record details of all the checks made to ensure the safe supply of medication. Each person on the service had an individual record sheet and prescription forms were checked against the records to ensure information was correct prior to dispensing beginning. A new record sheet was written following changes to medication regimens and historic sheets were dated and kept for reference purposes. A sample of assembled packs included full dispensing audit trails and descriptions of the medicines inside to help people recognise them. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. And it recorded the start date on each pack to help people manage their medicines.

A Care Service Customer Partner led the care home team. A pharmacist provided regular site visits to care homes to support them in managing their medicines. And a dedicated full-time ACT worked in the care home dispensary. The pharmacy supplied most homes with medicines in original packs. And pharmacy team members discussed how they had implemented changes from dispensing in multi-compartmental compliance packs to original packs to the majority of homes. The changes had included pharmacy staff completing training with care teams prior to the roll-out of the new system. The pharmacy checked prescriptions received against re-ordering Medication Administration Record (MAR) sheets returned from homes. Queries were recorded and sent to the homes for missing prescriptions or changes to medication regimens. And carbon copied communication sheets were used to record queries and conversations with care home teams. A daily communication diary was used to record simple non-patient specific queries such as the receipt of prescriptions. Tubs were used throughout the dispensing process and separated each person's medication. MAR sheets and completed PIFs were held with prescription forms in each tub. Medicines were supplied in multi-compartmental compliance packs to a small number of homes.

The pharmacy had audit trails in place for its FRPS service. This allowed it to ensure the required medicines were correctly prescribed. And meant that it could chase queries about missing prescriptions or changes to medication with GP surgeries in a timely manner. One member of the team had a dedicated role in providing this service. And this allowed her to communicate effectively with surgeries and people on the service when managing queries. Support was provided from other team members when required.

The pharmacy used tubs throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also signed a 'quad stamp' on prescription forms to indicate who had assembled the medicines, clinically checked the prescription, accuracy checked the medicines and handed out the medicines. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service and people signed an electronic point of delivery device (EPOD) to confirm they had received their medicine. The pharmacy used cool units to transport cold chain medicines through its delivery service. These were fitted with a thermometer and a driver explained how the EPOD prompted the driver to record the current temperature of the unit upon delivery of the medicine.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The RP and assistant manager demonstrated an awareness of the aims of the Falsified Medicines Directive (FMD). They understood that a new computer software programme was being rolled out by the company which would assist with compliance in the long-term. The pharmacy had not received any dates for the implementation of the new system. The pharmacy received drug alerts through the intranet. Details of alerts were checked across all three dispensaries prior to the team completing an audit trail confirming the alert had been read and acted upon.

The pharmacy stored Pharmacy (P) medicines behind the healthcare counter. This meant the RP could supervise sales taking place and was able to intervene if necessary. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. Dividers within drawers helped separate LASA medicines. The pharmacy team followed a date checking rota. This helped to manage stock and identify short dated medicines. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary

stock. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. Medicine storage arrangements in the cabinets included a separate cabinet for holding assembled doses of substance misuse medicines. The pre-assembly of these medicines against the current prescription reduced the risk of workload pressure when a person attended for their medicine. Assembled CDs were held in clear bags with details of the prescription's expiry date annotated clearly. The pharmacy highlighted all CD prescriptions to prompt additional safety and security checks during the dispensing process. The pharmacy had four fridges, including a fridge in the care home and FRPS dispensary. All fridges were clean and stock inside was stored in an organised manner. The team checked the temperature of the fridges daily. Temperature records confirmed that the fridges were operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs for providing its services. It monitors equipment to ensure it remains safe to use. And its team members use the equipment and facilities 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. And the RP explained how she used reference resources such as Stockley's to assist her in making clinical decisions.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Pharmacy team members had personal 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. The pharmacy team members managed some workload on the front dispensing bench. They removed any personal identifiable information between serving people and when walking away from the area. The pharmacy had cordless telephone handsets in place. Pharmacy team members moved to the back of the dispensary, out of ear shot of the public, when speaking with people on the phone. This meant that the privacy of the caller was protected.

Clean, crown stamped measuring cylinders were in place. Cylinders for use with methadone were clearly marked and stored separately. Counting equipment for tablets and capsules was available. This included separate equipment for counting cytotoxic medicines. Heat sealing equipment used in the assembly of some multi-compartmental compliance packs was regularly checked to ensure it remained in good working order. And electrical safety tests took place at scheduled intervals, the next check was due in December 2019.

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.