General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7 Silver Street, Coningsby, LINCOLN, Lincolnshire, LN4 4SG

Pharmacy reference: 1034301

Type of pharmacy: Community

Date of inspection: 31/10/2019

Pharmacy context

This is a community pharmacy in a large rural village in 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-compartmental compliance packs, designed to help people remember to take their medicines.

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	N/A	N/A	N/A
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 people's private information secure. And it advertises how people can feedback about its services and it responds appropriately. 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 understand how to recognise, and report concerns to protect the health and wellbeing of vulnerable people. The pharmacy generally keeps all records it must by law. But some gaps in these records occasionally result in incomplete audit trails. This may make it more difficult for the pharmacy to resolve a query should one occur.

Inspector's evidence

The pharmacy had a set of up-to-date 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. Training records confirmed that most pharmacy team members had signed to confirm they had read and understood the SOPs. But some newer members of the team had yet to sign some SOPs associated with their roles. A trainee pharmacy advisor explained the pharmacy could not open if a responsible pharmacist (RP) was not signed in. And she had a clear understanding of what tasks could not take place if the RP took absence from the premises. The accuracy checking technician (ACT) discussed how she applied her professional judgement and was confident when referring queries to the pharmacist. She demonstrated how pharmacists physically marked prescription forms to confirm a clinical check of the prescription was completed ahead of the accuracy check taking place.

The dispensary had limited work bench space. As such the team managed the multi-compartmental compliance pack service in a separate room. Some shelving in the main dispensary helped to organise workflow as trays of medicines waiting to be checked were held on these shelves. This meant dispensary work benches remained free from clutter. Separate areas of the dispensary were used for labelling, assembly and accuracy checking. Pharmacy team members used 'Pharmacist information Forms' (PIFs) to communicate key messages such as changes to medicine regimens, interactions and eligibility for services to pharmacists and the ACT. 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 generally attached to prescriptions. But the PIF was not always retained and used when an owed medicine was assembled.

The pharmacy had recently implemented a new clinical software programme. Pharmacy team members explained how some teething problems associated with the new system had led to a backlog of work. But they demonstrated how their workload management had improved since the initial troubles. And they were positive when discussing and demonstrating some of the new safety features of the system. For example, the new system required pharmacy team members to scan their stock selection. And it informed the team member if they had selected the wrong product. The programme only generated a dispensing label if the scanned product matched the item on the prescription.

The pharmacy had a near-miss error reporting procedure. This usually involved the pharmacist or ACT

informing the member of staff involved of their mistake. And pharmacy team members corrected their own mistakes whenever possible. The pharmacy consistently reported its near-miss errors on a formal record. There were some opportunities in the record to expand more on the contributory factors and learning following a mistake. The pharmacy reported its dispensing incidents through the 'Pharmacy Event and Incident Reporting System' (PIERS). The manager provided access to PIERS which provided confirmation pharmacy team members reported incidents in accordance with the pharmacy's procedures.

Pharmacy team members regularly discussed their mistakes with each other. And learning following an incident was shared with the team to help identify areas for improvement. The RP demonstrated how improvements to storage arrangements for some assembled medicines had been implemented following feedback from a recent incident. The pharmacy manager had recently led the team's monthly patient safety review. This involved looking at patterns in mistakes and implementing risk reduction actions to help prevent similar mistakes occurring. The quality of the written review was good with trends in mistakes clearly identified and actions recorded to help reduce risk when dispensing. Details of the review was shared one-to-one or in short briefings. There was the potential to hold more detailed structured meetings to help share learning as a team. The team demonstrated some actions taken to reduce risk for example, completing thorough self-checks of their work and highlighting key information on prescription forms to prompt additional checks during the dispensing process. Pharmacy team members also identified 'look-alike and sound-alike' (LASA) medicines on PIFs.

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. The pharmacy also promoted feedback through an online questionnaire and through its annual 'Community Pharmacy Patient Questionnaire'. A pharmacy team member discussed how recent learning had taken place in response to feedback relating to handing out some and not all of a person's medication. This learning had included the need for pharmacy team members to check people's medication records and confirm what medicine was expected during the hand out process.

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 generally complied with legal requirements. But there was a missed entry in the register in September 2019. The pharmacy retained an audit trail for its CD keys. And a couple of gaps in this record were also noted during September 2019. A sample of the CD register found that it generally met legal requirements. Page headers were occasionally incomplete. For example, the formulation of methadone was not always completed. Mistakes in the register were recorded with clear footnotes and no crossing out. The pharmacy occasionally omitted the address of the wholesaler when entering receipt of a CD in the register. The pharmacy maintained running balances in the register. Balance checks of the register against physical stock took place weekly. A physical balance check of Medikinet 30mg modified release capsules complied with the balance in the register. A CD destruction register for patient returned medicines was maintained and the team entered returns in the register on the date of receipt. A sample of the pharmacy's Prescription Only Medicine (POM) register and specials records confirmed these were being kept in accordance with legal and regulatory requirements.

The pharmacy held records containing personal identifiable information in staff only areas of the pharmacy. 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. Pharmacy team members demonstrated vigilance when working at the open plan work stations at the front of the dispensary. 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 and ACT had completed level two learning through the Centre for Pharmacy Postgraduate Education (CPPE). A pharmacy team member demonstrated a sound understanding of how to recognise and report safeguarding concerns. And pharmacy team members made each other aware of any minor concerns they had to help monitor situations if required. The pharmacy shared concerns about people's health and compliance with medicine regimens with surgeries when required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. It responds appropriately when additional staffing resources are required to support the safe running of the pharmacy. The pharmacy promotes how its team members can provide feedback. And it acts appropriately by responding to this feedback. The pharmacy supports its team members in their roles. And pharmacy team members engage in regular conversations about managing their workload and patient safety. But there are some opportunities to provide regular learning time and structured meetings to further encourage continual learning.

Inspector's evidence

On duty during the inspection was the RP, pharmacy manager, an ACT, two qualified pharmacy advisors (qualified dispensers) and three trainee pharmacy advisors. The pharmacy also employed another two qualified pharmacy advisors and another trainee pharmacy advisor. The pharmacy had experienced a high turnover of staff in the last year. This had resulted in four team members in training roles. A part-time ACT and a full-time pharmacy advisor had recently left the pharmacy. The manager confirmed the staffing levels and skill mix of pharmacy team members had been reviewed and the pharmacy had taken the decision to fill the vacancies with qualified dispensers. The roles had been recruited to at the time of inspection. The pharmacy also had one team member on long-term leave. The manager confirmed there was some flexibility from part-time members of the team to support in covering this leave. And more recently the manager had requested additional support from other stores to help manage absences caused by approved annual leave. The manager confirmed double-up pharmacist cover had been provided on occasion when concerns over staffing had been expressed.

Pharmacy team members received time when required for mandatory training. But they did not receive regular protected training time to assist them in their continual learning. The RP supported all trainee team members. Due to the number of staff in training roles this learning was taking longer than the agreed timescales in some cases. But all staff were on track to complete the learning within the timescale indicated within GPhC guidance for the minimum training requirements of pharmacy support staff. Trainee members of the team confirmed they felt supported and were confident in asking questions related to their roles. The RP discussed the need to ensure all staff had the relevant experiences to support their learning rather than rush the learning to meet a timescale. And this approach helped to manage the risks associated with team members in training roles. Each member of the pharmacy team received a regular appraisal with their manager. The current manager was a qualified pharmacy advisor, she had been in place for approximately two months.

Pharmacy team members expressed that they had experienced a difficult year. But they were positive and spoke highly of the support they received from the manager and RP. The RP discussed how she approached her workload and she was able to apply her professional judgement in the interests of people visiting the pharmacy. Both the manager and RP had no concerns about targets the pharmacy was set relating to its services. They explained the current focus was on improving timescales associated with dispensing activity and felt confident that they would achieve other targets for services such as Medicines Use Reviews (MURs). The RP was observed making herself available to speak with people and to provide the flu vaccination service during the inspection.

Pharmacy team members communicated through informal briefings. The manager had recognised the need to provide some structured feedback to the team and a formal out-of-hours meeting had been arranged for November 2019. The manager explained this would help the team to review their progress with work since the introduction of the new computer system. And to identify areas where further focus was required. A discussion took place about the benefits of regularly holding formalised meetings to help share learning between pharmacy team members. The RP had recently implemented some noticeboards in the dispensary. And the pharmacy displayed its patient safety review on the board for staff to refer to. It also held some signposting information and date checking information on the board.

The pharmacy had a whistleblowing policy. And members of the team spoken to confirmed they were aware of how to raise and escalate concerns at work. Pharmacy team members were confident at providing feedback. Concerns relating to the pharmacy's medication fridge had been escalated to the pharmacy's area manager. And the pharmacy had received a second fridge in response to the team members concerns as the issue was thought to be caused by the amount of stock in the fridge.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. The premises are safe and maintained to the standards required. But some fixtures and fittings require close monitoring to ensure minor repairs do not progress to become health and safety concerns. Pharmacy team members promote the use of the private consultation room when speaking to people accessing the pharmacy's services.

Inspector's evidence

The pharmacy was secure, and it provided a professional image to people visiting. The public area was fitted with wide spaced aisles which allowed easy access to people using wheelchairs or pushchairs. To the side of the public area was access to a store room and the pharmacy's consultation room. The pharmacy's consultation room was large and easily accessible to all. It was professional in appearance and provided a suitable space for private consultations to take place. The RP was observed using the room with people attending the pharmacy during the inspection.

The dispensary was a sufficient size, it was an unusual layout due to the age and structure of the premises. But pharmacy team members were observed using space efficiently. A large room to the side of the dispensary had work benches fitted. And work associated with the multi-compartmental compliance pack service was completed in this room. The room also acted as a staff room. And a separate table for staff to sit and eat was provided for this purpose. There was also a dedicated bench where the facilities for staff to make drinks were located. Off this room was access to a staff toilet and stairway leading to the first-floor level of the premises. The first-floor level consisted of one room which was used to hold archived records, dressings and dispensary sundries.

The pharmacy team reported maintenance concerns to a designated support desk. There were several maintenance issues found in the dispensary where drawer and cupboard fronts had become detached. The fronts of the units were removed completely to ensure the dispensary remained safe. The team members confirmed these issues had been reported when they had happened. But no action to fix the fittings had taken place. The premises was old and as such there were some cosmetic issues in staff only areas of the pharmacy. Antibacterial hand wash and paper towels were available at designated hand washing sinks. The pharmacy was generally clean. There were some dust and cobwebs noted on the stairway and on the first-floor level of the pharmacy. But working spaces and medicine storage areas were kept clean and free from clutter. The pharmacy was heated and cooled by air conditioning in the dispensary and public area. It used electric heaters in the side room and consultation room. Lighting was sufficient throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and it makes them accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services. And its team members follow these procedures. Pharmacy team members provide additional information to people taking high-risk medicines to help them to take their medication safely. And they work effectively with other healthcare providers. The pharmacy obtains its medicines from reputable sources. It stores and mostly manages its medicines safely and securely.

Inspector's evidence

The pharmacy was accessed through a power assisted door at street level. It clearly advertised its opening times and services through window displays. It had a range of service and health information leaflets available to people. And pharmacy team members explained how they engaged people in conversation about the pharmacy's services and healthy living campaigns when able. They confirmed there had been a focus on providing essential services during the last few months due to the fluctuating staffing levels and tasks taking longer whilst they familiarised themselves with the new pharmacy software programme. Pharmacy team members were aware of how to signpost people to another pharmacy or healthcare provider if they were unable to provide a service. Designated seating was available 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 was the regular pharmacist. She discussed how she took opportunities to speak to people about their health and medicines. And beneficial outcomes from the services provided were discussed. For example, detecting possible atrial fibrillation when completing a blood pressure check. The RP also explained how she worked with the neighbouring surgery to share information. For example, details of out-of-stock medicines. A recent meeting with the surgery had led to the RP implementing a 'GP query form'. The RP had amended this form following feedback. These amendments had included adding a prompt for pharmacy team members to check with the prescriber prior to sending a query to help ensure information was being sent to the correct surgery.

The pharmacy used trays throughout the dispensing process. This kept medicines with the correct prescription form. Prescriptions for people waiting in the pharmacy were prioritised and brought to the direct attention of the RP. 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.

The pharmacy had systems to identify people on high-risk medicines. For example, it stored valproate preparations and anti-diabetic medicines away from other medicines to identify these as high-risk. Pharmacy team members were aware of the requirements of the valproate pregnancy prevention programme (PPP) and explained how it was necessary to inform the pharmacist if the pharmacy received a prescription for a person in the high-risk group. High-risk warning cards associated with PPP

counselling were readily available to issue to people in the high-risk group. Pharmacy team members attached bright cards to prescriptions to identify additional monitoring checks for high-risk medicines. For example, paediatric medicines, warfarin, methotrexate and lithium. Pharmacy team members could demonstrate monitoring records associated with the checks made when warfarin was handed out to a person. The pharmacy also identified its cold chain medicines and CDs. These medicines were held in clear bags once assembled. And bright warning cards and stickers prompted safety checks prior to hand-out to a person.

Every person receiving a multi-compartmental compliance pack had a profile sheet in place. A four-week schedule was used to spread workload across the month. The dispenser managing the service had very recently moved to the pharmacy. And she was in the process of reviewing the service with pharmacist and manager support. As part of this review the pharmacy had plans to fully train a second dispenser to support the service. Other members of the team could undertake some tasks associated with the service to support it if required. The dispenser explained how she would check changes to prescription regimens with prescribers. But the pharmacy did not always record details of these checks to support it in managing these types of queries. A sample of assembled packs contained full dispensing audit trails and descriptions of medicines inside the packs. The pharmacy supplied Patient information leaflets (PILs) with packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The team had limited knowledge of the Falsified Medicines Directive (FMD). They explained that the new clinical software programme had been brought in to support compliance with FMD requirements. They had not received any training related to FMD to date. But they could discuss changed to medicine packaging including new tamper proof packs.

The pharmacy stored medicines in an orderly manner and within their original packaging. A date checking rota was in place. The team members acknowledged that date checking against the three-monthly cycling rota had fallen behind schedule. But the team was trying to get this back on track. The team annotated details of opening dates on bottles of liquid medicines and it highlighted short-dated medicines. No out-of-date medicines were found during random checks of dispensary stock.

The pharmacy held CDs in secure cabinets. There was a designated area for storing patient returns, and out-of-date CDs within the stock cabinet. The pharmacy had two fridges for the purpose of storing medicines. These were clean, and a sufficient size for the cold chain medicines held. It held stock in one fridge and assembled medicines in another. Temperature records confirmed that both fridges were operating between two and eight degrees Celsius.

The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It received drug alerts electronically. And it maintained an audit trail of alerts confirming that it checked all alerts within a timely manner. All alerts were actioned to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And it regularly monitors its equipment to ensure it remains in working order. Pharmacy team members manage and use the 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 clean, crown stamped measuring cylinders for measuring liquid medicines. Cylinders for use with methadone were clearly marked. Counting equipment for tablets and capsules was available. This included separate equipment for counting cytotoxic medicines. The pharmacist used an Omron blood pressure machine to check people's blood pressure upon request or when undertaking consultations with people. For example, during a MUR. The machine was used for screening purposes only. The pharmacy held equipment to support the seasonal flu vaccination service within its consultation room. For example, adrenaline autopens. The pharmacy's electrical equipment was safety tested. The date of the next scheduled check was May 2020.

Computers were password protected and faced into the dispensary. This prevented unauthorised view of information on computer screens. Most pharmacy team members had working NHS smart cards. The pharmacy stored assembled bags of medicines waiting for collection and delivery on shelves 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. Pharmacy team members moved to a side room, out of ear shot of the public, 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.