General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 73 - 76Corn Lane, Swansgate Centre, WELLINGBOROUGH, Northamptonshire, NN8 1EZ

Pharmacy reference: 1035517

Type of pharmacy: Community

Date of inspection: 05/02/2020

Pharmacy context

This community pharmacy is situated in a shopping centre in the middle of the town. Most of the activity is dispensing NHS prescriptions, both to people living in their own homes and in care homes; and giving advice about medicines over the counter. Other services that the pharmacy provides include substance misuse services, seasonal flu vaccinations against patient group directions, prescription deliveries to people's homes, Medicines Use Reviews (MUR) and New Medicine Service (NMS) checks.

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	1.1	Good practice	The pharmacy continually monitors the safety of its services to protect and further improve people's safety. It identifies risks and takes action to address these.
		1.6	Good practice	The pharmacy keeps all its records up-to-date and these show it is providing safe services.
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	4.2	Good practice	The pharmacy team is helpful and supportive to people who use the pharmacy. It identifies higher-risk medicines and has good processes in place to support people to take their medicines safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy continually monitors the safety of its services to protect and further improve people's safety. It identifies risks and takes action to address these. Its team members have defined roles and accountabilities. The pharmacy has processes for learning from its mistakes. The pharmacy keeps all its records up-to-date and these show it is providing safe services. The pharmacy adequately manages people's personal information. It 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. The pharmacy had a dispensary in the public area which dispensed original packs for people who lived in the community. There were two rooms downstairs which were used for dispensing medicines for people who lived in care homes and people living in the community who had medicines in a multi-compartment compliance pack.

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SOPs had been signed by the pharmacy team. 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. Downstairs the care home team had a PIF for care homes that included additional information such as allergies. A member of the team explained the principle behind the look-alike, sound-alike (LASA) protocol. 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 these medicines should be written on the PIF. PIFs checked in the dispensary and the care home room had the name of the medicine on them.

The pharmacy also had a number of prompt cards. Cards said if there was a controlled drug (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 member of staff handing out the medicine should ask the person collecting the prescription. Prescriptions seen had a suitable prompt card attached.

The counter assistant knew how to sell a medicine safely. She explained that there were different questions depending on whether the person asked for advice or for a specific medicine. She had a good product knowledge. She knew that most prescriptions were valid for six months and that prescriptions for CDs were valid for 28-days after the date on the prescription. She could recall the CDs that were not kept in the CD cupboard. Prescriptions with CDs seen were highlighted and the date after which the prescription could not be supplied was recorded.

The pharmacy had a system for managing all prescriptions waiting collection. After the prescription had been checked the person was texted to tell them their medicine was ready. All people who had a dispensed prescription at the pharmacy were sent a text on a to remind them to collect it.

The pharmacy kept records of near misses, errors and incidents. Near misses were discussed with the member of staff responsible at the time they were found. A record was then made in the near miss log. At the end of the month a patient safety review was carried out. The January review was on display in

the dispensary. It had been signed by staff. The review highlighted the need to be consistent with PIFs and laminates. The pharmacist showed action that had been taking as a result of near misses including highlighting different strengths of atorvastatin. She explained how she raised concerns in team meetings. Downstairs in the care homes room the December review was also on display. The member of staff asked could recall the key points of the review. The review highlighted that near misses weren't being recorded and reminded staff of the need to record them. There had been a large increase in the number of near misses recorded in January.

The pharmacy provided NHS and private for flu vaccinations. There was a folder with guidance for staff; PGDS were in date and had been signed. There was evidence of training and the declaration of competence was completed.

The latest patient satisfaction survey from March 2019 was on the NHS UK website. 80% of people who had completed the survey had rated the pharmacy as excellent or very good. There was a complaints procedure in place. There were contact details for Boots customer care service on the back of till receipts. The care home manager had quarterly meetings with the care homes to discuss any issues.

Public liability and professional indemnity insurance were in place. The pharmacy had records to support the safe and effective delivery of pharmacy services. The CD register was completed correctly; CD running balances were checked regularly. A random check of the recorded running balance of a CD reconciled with the actual stock. Out-of-date and patient-returned CDs were clearly marked and separated. There was a record of patient returns which included Schedule 3 CDs. Private prescriptions were recorded electronically. The prescription checked had the correct prescriber on the electronic record.

Computer terminals were positioned so that they couldn't be seen by people in the retail area. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was bagged and sent away for secure destruction.

Confidential information was stored securely. There was an information governance protocol in place. The pharmacy team was aware of the safeguarding procedure; the pharmacist had completed appropriate training. Local contact details were available if the pharmacy needed to raise any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. Team members work well together and adequately manage the workload. They can raise concerns if needed. The team members receive support in keeping their skills and knowledge up to date.

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 the inspection the pharmacy had a pharmacist, three qualified dispensers and a counter assistant. The care home team consisted of a pharmacist, two accuracy checking technicians; and three dispensing assistants.

The pharmacy team worked well together during the inspection. Staff said that they had an annual appraisal and that they found the pharmacy manager easy to speak to. They felt able to raise concerns if necessary. Staff said their development was supported. There was a range of training for all staff on the e-Learning site; staff were up to date with this training. Most staff said that they also completed the monthly 30-minute tutors, but some said that they had not completed one for some time. There was also informal training from the pharmacist. Although targets for services were set the pharmacist said they didn't compromise customer service or his professional integrity.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy protects personal information.

Inspector's evidence

The pharmacy was maintained to a suitable standard. The dispensary was a reasonable size for the services provided. The dispensary was clean and tidy and 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.

There were separate areas for the assembly and checking of medicines. There were two rooms downstairs which were used for dispensing medicines for people who lived in care homes and people who had medicines in a multi-compartment compliance pack. These rooms were suitable for the services that were provided.

A small-sized consultation room was available and used to ensure that people could have confidential conversations with pharmacy staff were appropriate and on request. Computer screens were set back from and faced away from the counter. Access to the 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. The pharmacy team is helpful and supportive to people who use the pharmacy. It identifies higher-risk medicines and has good processes in place to support people to take their medicines safely. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it 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 situated in the shopping centre in the middle of town. The pharmacy had automatic double doors to provide easy access for wheelchairs and those with mobility problems. Opening times were displayed; staff had uniforms and name badges so that they could be clearly identified. The pharmacist had an understanding of signposting and knew how to direct people to local health services.

Work was prioritised based on whether the prescription was for a person who was waiting or coming back. 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. An audit trail was created using 'dispensed by' and 'checked by' boxes on the dispensing label and the use of the quad box on the prescription. The final check was carried out by the RP or the Accuracy Checking Technician (ACT). The ACT asked explained how this process worked with a clinical check by the pharmacist before the prescription was dispensed.

During the inspection the pharmacist was easily available to speak to people visiting the pharmacy. The pharmacist said that she gave advice to people using the pharmacy on a range of matters including dose changes, new medicines and any additional advice include in the PIF. She also highlighted children's medicine and unusual doses. She explained how the previous day she had rung a GP about a high dose for an opioid naïve patient and got it changed. During the inspection both pharmacists had conversations with doctors about people's medicines. The pharmacist said that in the dispensary people who had warfarin had their INR checked and recorded. Downstairs warfarin was not supplied until an INR had been received. Records for both these processes were seen. Advice was given to people taking methotrexate. Insulin was handed out in a clear bag so that it could be checked with the person receiving it. The care home team kept records to make sure that people taking lithium had their levels checked every three to six months. The communication book recorded interventions for all the homes they provided a service to. The pharmacist said they regularly gave advice to the carers. The pharmacist was aware of the advice about pregnancy prevention that should be given to people in the at-risk group taking sodium valproate. The pharmacist had carried out an audit on sodium valproate and had one person within the at-risk group. She had spoken to her. The pharmacy had appropriate leaflets.

The care homes room had a chart on display to make sure that people in care homes and people who received their medicine in a compliance pack got them in time. Care homes ordered their own medicines. If there was a missing item or a change the home was contacted before the supply was made. Each person who had a compliance pack had an individual record which listed their medicines and when they should be taken. The medicine administration chart (MAR) charts recorded the shape and colour of the medicine to allow easy identification. Patient information leaflets (PILs) were

routinely sent. The pharmacy had recently assessed each person to make sure a compliance pack was suitable for them.

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. One bottle checked didn't have the date of opening recorded despite the fact that it had a short expiry date once opened. The pharmacy delivered medicines to people.

The person who received the medicine signed for the medicine to create an audit trail. Only recognised wholesalers were used for the supply of medicines. The pharmacy team was aware of the procedure for drug alerts. A record was created and signed to provide a complete audit trail. The pharmacist was aware of the Falsified Medicines Directive and was waiting for new computer software to implement the directive.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids; separate measures were used for CDs. The pharmacy had a range of up-to-date reference sources. Electrical appliance testing was next due in March 2020. CDs were stored securely. Fridge temperature checks were within range. Records showed that medicines in the fridge were stored correctly within the range of 2 and 8 degrees Celsius.

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.