General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 14-15 Stodman Street, NEWARK, Nottinghamshire, NG24 1AT

**Pharmacy reference:** 1035585

**Type of pharmacy:** Community

**Date of inspection:** 25/04/2019

## Pharmacy context

The pharmacy is situated along one of the main shopping streets in a market town. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

## 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 | 1.8 | Good practice | Pharmacy team members are particularly good at using their knowledge and skills to protect the welfare of vulnerable people. |
| **2. Staff** | Standards met | 2.5 | Good practice | The pharmacy encourages its team members to provide feedback. And their feedback has been acted upon to inform the management of the pharmacy's services. |
| **3. Premises** | Standards met | 3.2 | Good practice | Pharmacy team members promote the use of the private consultation room when speaking to people accessing the pharmacy's services. |
| **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 has appropriate systems in place to identify and manage the risks associated with the services it delivers. It keeps all records it must by law. The pharmacy advertises how people can provide feedback. And it manages feedback appropriately. It has systems in place which ensures that it keeps people's private information confidential. Pharmacy team members are clear about their roles and responsibilities. But they have not all signed training records associated with the pharmacy's procedures. This may mean that there is inconsistency in the team when completing tasks associated with service delivery. Pharmacy team members share learning. And they show how they work to reduce risks during the dispensing process following a mistake occurring. They are particularly good at using their knowledge and skills to protect the welfare of vulnerable people.

### 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. Training records confirmed that some members of the team had completed training associated with SOPs. But there were gaps in some training records. For example, not every member of the pharmacy had signed to confirm that they had read and understood SOPs related to date checking and the sale of medicines. Pharmacy team members on duty were familiar with details within SOPs and demonstrated compliance with most SOPs. A pharmacy advisor explained what tasks could and could not take place if the responsible pharmacist (RP) took absence from the premises.

The dispensary was organised with workflow effectively managed. Shelving was used to store baskets and tubs of assembled medicines waiting for accuracy checking. Separate areas of the dispensary were used for labelling, assembly and accuracy checking. The pharmacy had a designated 'Medisure' room on the first-floor level for completing tasks associated with the multi-compartmental compliance pack service. 'Pharmacist information Forms' (PIFs) were used to communicate key messages such as changes to medicine regimens, interactions and eligibility for services to pharmacists. 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 prescriptions.

The pharmacy had very recently implemented a new clinical software programme. The team demonstrated safety features of the new programme. For example, pharmacy team members scanned in the receipt of stock. They also scanned individual medicines during the dispensing process. The programme only generated a dispensing label if the scanned product matched the item on the prescription. The team were exploring more features of the programme as they became confident in using it. They were competent in demonstrating intervention records and pharmacy records maintained on the programme.

There was a near-miss reporting procedure in place. The near-miss reporting form captured details of the type of mistake which had occurred and contributory factors. Near-miss reporting was generally consistent. But a record from April 2019 was missing. The RP provided verbal assurance that the record was maintained during this time; the person who reviewed near-misses was not on duty at the time of

inspection to comment. The pharmacy reported its dispensing incidents through the 'Pharmacy Event and Incident Reporting System' (PIERS). The RP demonstrated incident reporting on the system and explained how she would manage a dispensing incident in accordance with the pharmacy's SOP for incident reporting. The team acted to reduce risk by identifying 'look alike and sound alike' (LASA) medicines on the dispensary shelves. A pharmacy advisor explained that LASA medicines should also be written on PIFs and the team were encouraged to do this during the dispensing process.

The pharmacy team completed monthly Patient Safety Reviews. The reviews included trend analysis of near-misses, details of prescribing incidents, dispensing incidents and medicine alerts, such as recalls. The team explained that both near-miss rates and incident rates had fallen since having the new clinical software programme in place. The programme helped to identify picking errors prior to the assembly of medicines. But picking errors identified by the programme were not captured as near-misses. A discussion took place about the advantages of recording these. And reducing the risk of complacency due to the improved safety features of the clinical software programme. Actions taken following patient safety reviews were re-visited as part of the following months patient safety review. This helped to monitor the effectiveness of the actions taken.

The pharmacy had a complaints procedure in place. A practice leaflet advertised how people could provide feedback to the pharmacy team. A member of the team explained how he would manage feedback and seek to resolve it or escalate it if required to the manager or RP. The team were aware of how to escalate concerns through to the pharmacy superintendent's team. The pharmacy engaged people in feedback through annual 'Community Pharmacy Patient Questionnaires'. The pharmacy also had cards available at the medicine counter which prompted online feedback. But a member of the team explained that these were not always handed out to people. The team explained that the majority of feedback was related medicine availability and people preferring certain brands of generic medicines.

The pharmacy had up to date insurance arrangements in place.

The RP notice displayed the correct details of the RP on duty. Entries in the responsible pharmacist record complied with legal requirements.

A sample of the CD register found that it generally met legal requirements. The pharmacy did not always record 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 Sevredol 10mg tablets 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. But there were over 3 pages of returns dating back to July 2018 awaiting destruction.

The pharmacy held the Prescription Only Medicine (POM) register electronically. Records for both private prescription and emergency supplies were clear and complied with legal requirements. The pharmacy completed full audit trails on certificates of conformity for unlicensed medicines as per MHRA record keeping requirements.

The team held records containing personal identifiable information in staff only areas of the pharmacy. The team had completed additional learning following the introduction of the General Data Protection Regulation (GDPR). Workload in the semi-open plan area of the dispensary was protected through staff vigilance. For example, pharmacy team members removed patient information from the work bench before leaving the area. The pharmacy team transferred confidential waste to blue bags. Bags were secured and collected for secure destruction periodically.

The pharmacy had procedures relating to safeguarding vulnerable adults and children. The team had access to contact details for local safeguarding teams. Pharmacy team members had completed e-learning relating to safeguarding. Pharmacists and the pharmacy technician had completed level 2 training on the subject. A member of the team explained how she would recognise and escalate a concern to the pharmacist. The RP on duty provided several examples of reporting safeguarding concerns.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff in place to provide its services. It has some systems in place to support its team with continual learning associated with their roles. The pharmacy encourages its team members to provide feedback. And it acts on their feedback to inform the management of the pharmacy's services. Pharmacy team members share learning following mistakes made during the dispensing process. And they engage in safety reviews to help reduce risk across the pharmacy. They are aware of how to raise a concern about the pharmacy or its services.

### Inspector's evidence

On duty at the time of the inspection was the RP (the full-time regular pharmacist), a pre-registration pharmacist and three qualified dispensers (pharmacy advisors). A pharmacy technician, a part-time resident pharmacist and another pharmacy advisor were also employed. The store manager and assistant manager were qualified pharmacy advisors. The assistant manager was on long-term leave at the time of inspection. Pharmacy team members explained that the manager supported them in completing dispensary duties regularly. A company employed driver provided the prescription delivery service.

The team were relatively up to date with workload at the time of inspection. But the team explained that they had struggled with workload management over the last month. This was due to Easter and the roll-out of the new clinical software programme. A glitch in the software had revealed that only a proportion of daily Electronic Prescription Service tokens were being downloaded and printed in the early stages of the roll-out. This had led to a back-log of work which the team had needed to manage. Although shelves holding work waiting to be checked were busy, the team had a plan in place for managing the workload. The team used a 'model day' matrix in the dispensary to manage tasks and track the completion of daily workload.

Pharmacy team members had access to some ongoing training relating to their roles. The pharmacy had put regular learning and protected training time on hold prior to the new clinical software programme being implemented. But some ongoing learning through discussion and reading newsletters was evident. The team had received training for the new clinical software programme. A pharmacy advisor was observed supporting another colleague in using the programme. The pre-registration pharmacist received training time and support. She had transferred her pre-registration training from another branch within the last few months. Pharmacy team members received regular feedback through performance reviews.

The pharmacy team discussed the range of targets in place from sales and service completion to customer service. The RP confirmed that there was no undue pressure in place to perform against targets. She explained that the manager was supportive and provided examples of how she managed services through applying her professional judgement.

Pharmacy team members communicated through 'huddle' meetings and one-to-one's. The team shared learning related to the outcome of patient safety reviews and the internal 'patient safety first' programme through regular briefings. A member of the team explained how the patient safety first programme aimed supported team members with maintaining compliance with SOPs.

Pharmacy team members were aware of the company's whistleblowing policy. They could explain how to raise and escalate a concern about the pharmacy or its services. Pharmacy team members were confident in putting forward ideas to help manage services. One team member explained how staff feedback had informed changes to the way the team communicated with people on the multi-compartmental compliance pack service.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean and secure. It presents a professional environment for the delivery of its services. 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 well maintained and secure. An up-to-date business continuity plan was in place. The pharmacy reported maintenance issues to a designated help-desk. The public area was open plan with the medicine counter and prescription reception counter accessed to the side of the public area. The pharmacy stored pharmacy only medicines behind the medicine counter. This appropriately protected them from self-selection.

The pharmacy was clean and tidy with no slip or trip hazards evident. Air conditioning was in place in the public area of the pharmacy. Lighting throughout the premises was bright. Antibacterial soap and paper towels were available close to the sink in the dispensary and at sinks in other staff areas of the premises.

The dispensary was a sufficient size for providing the pharmacy's services. On the first-floor level of the premises was the Medisure room, warehouse, offices and meeting rooms. The team stored medical waste and dispensary sundries in the warehouse. A second-floor level of the premises provided access to staff toilet facilities.

There was a private consultation room in a quiet corner next to the dispensary. It was sound proof and clearly signposted. It was professional in appearance and allowed for confidential conversations to take place. The team routinely asked people requesting a quiet word if they wished to use the room. It was observed being used with people several times during the inspection. Pharmacy team members also used cordless telephone handsets when speaking to people over the phone. They were observed moving to the enclosed area of the dispensary when holding private conversations. This prevented people in the public area from overhearing details of the conversations taking place.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy is accessible to people. And it provides services that support people's health needs. The pharmacy gets its medicines from reputable suppliers. It stores medicines safely and securely. And has some systems in place for ensuring that medicines are fit to supply. Pharmacy team members generally follow procedures in place for managing the pharmacy's services. They maintain records related to the services they provide. And they take extra care when dispensing high-risk medicines.

### Inspector's evidence

The pharmacy had two entrances from street level. One had automatic doors which assisted people with access. Opening times and details of the pharmacy's services were clearly advertised. It had a range of service and health information leaflets available to people. This included the pharmacy's practice leaflet. 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. There was a hearing loop available.

A small corner of the public area was used to promote healthy living. The display was relatively out of sight of the main public area. But it was likely to be seen by people using the consultation room. A pharmacy advisor confirmed that the display did not prompt much engagement from people. But there were frequent requests at the medicine counter from people wishing to speak to the pharmacist. Pharmacy advisors were also observed providing thorough advice when managing queries and requests for pharmacy only medicines. The RP reflected on the beneficial outcomes of services. For example, providing advice and support to females requesting emergency hormonal contraception and males purchasing treatment for erectile dysfunction. There was evidence of pharmacists applying their professional judgement and considering the safety of people when refusing the sale of a pharmacy only medicine which was deemed inappropriate.

The pharmacy used tubs and baskets throughout the dispensing process. This kept medicines with the correct prescription form. 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 prescription. 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. It maintained delivery audit trails for the prescription delivery service. People were asked to sign an electronic device at the point of delivery to confirm that they had received their medicine.

The pharmacy had systems to identify people on high-risk medicines. Pharmacy team members attached bright cards to prescriptions to identify additional monitoring checks for paediatric prescriptions, warfarin, methotrexate and lithium. Cold chain medicines and CDs were also clearly identified, and the team explained additional checks they made when handing out high-risk medicines. A member of the team demonstrated how monitoring checks for warfarin were available on the new clinical software programme. Pharmacy advisors on duty struggled to identify the requirements of the 'Valproate Pregnancy Prevention Programme' (VPPP). They explained that they rarely dispensed valproate preparations. But valproate warning cards were available. And the RP confirmed that learning had been shared with the team. The RP provided assurance that pharmacists were fully compliant with VPPP requirements when dispensing valproate.

Every person receiving a multi-compartmental compliance pack had a profile sheet in place. A four week schedule was in place which spread workload across the month. Audit trails detailing the stage each pack was at were maintained on a progress board in the Medisure room. Changes to medicine regimens were queried with surgeries. But they were not always tracked on profile sheets or on the persons medical record. Some assembled packs waiting to be checked did not have a completed PIF with them. This meant that a pharmacist's attention may not be drawn to changes in people's medicine regimens. 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 4-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The team were aware of the Falsified Medicines Directive (FMD). They explained that the new clinical software programme had been brought in to support compliance with FMD requirements. But they had not received any training related to FMD to date. The pharmacy's SOPs did include details of FMD compliance. The team scanned the product barcode rather than the individual unique 2D barcode associated with FMD during the dispensing process.

The pharmacy stored medicines in an orderly manner and generally in their original packaging. A couple of medicines were stored in white boxes. But without full details of the medicine inside each box annotated on the boxes. This meant that appropriate checks of the expiry date and batch number of the medicine may not be applied when date checking, dispensing or responding to medicine alerts. A date checking rota was in place. The team completed rolling quarterly checks of all stock. A system was in place for highlighting 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 held CDs in a secure cabinet. Medicines storage inside the cabinet was orderly. But some other items were also held in the cabinet which was not ideal. For example, a member of the publics lost purse. There was a designated area for storing patient returns, and out-of-date CDs within the cabinet. The pharmacy's fridge was clean, and it was a sufficient size for the cold chain medicines held. Temperature records confirmed that it was operating between two and eight degrees. The pharmacy held assembled CDs and cold chain medicines in clear bags. This prompted additional checks of the medicines inside prior to hand-out. CD's had details of the 28-day expiry date annotated on the clear bags.

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

The pharmacy received drug alerts through the intranet. There were no outstanding alerts waiting for action at the time of inspection.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy team has access to equipment for providing its services. The pharmacy has monitoring systems in place to ensure equipment is safe to use and fit for purpose.

### 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. Computers were password protected and faced into the dispensary. This prevented unauthorised access to the contents on screen. Pharmacy team members had personal NHS smart cards.

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 a separate triangle for use with cytotoxic medicines. Equipment for the multi-compartmental compliance pack service was single use. Gloves were available if required. Equipment for the treatment of anaphylaxis shock was stored in the consultation room with sharps bins. The consultation room was locked between use to safeguard equipment inside. Stickers on electrical equipment showed that safety testing was next due in March 2020.

## 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. |