General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 31 High Road, Beeston, NOTTINGHAM, Nottinghamshire, NG9 2JQ

Pharmacy reference: 1035657

Type of pharmacy: Community

Date of inspection: 04/06/2019

Pharmacy context

The pharmacy is on the main shopping street in a town on the outskirts of Nottingham. 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 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 have a clear understanding of how to safeguard vulnerable people. And they act vigilantly to protect the welfare of these people.
2. Staff	Standards met	2.5	Good practice	The pharmacy promotes ways in which its team members can provide feedback. And it has used this feedback 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	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 processes to identify and manage the risks associated with the services it delivers. It generally keeps all records it must by law. But some gaps in these records occasionally result in inaccurate and incomplete audit trails. The pharmacy advertises how people can provide feedback about its services. And it responds appropriately to people who choose to provide feedback. The pharmacy manages people's private information securely. Pharmacy team members act openly and honestly by sharing information when mistakes happen. And they take part in regular learning to help reduce identified risks. Pharmacy team members have a clear understanding of how to safeguard vulnerable people. And they act vigilantly to protect the welfare of these 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. A sample of training records confirmed that members of the team had completed training associated with SOPs. 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.

The dispensary was small, but workflow was organised and effectively managed. Shelving was used to store tubs and trays of assembled medicines waiting for accuracy checking. Managed workload was annotated with dates the medicines were due for collection or delivery. Separate areas of the dispensary were used for labelling, assembly and accuracy checking. The pharmacy had a separate 'Medisure room' on the first-floor level for completing tasks associated with the multi-compartmental compliance pack service. This provided protected space for carrying out tasks associated with supplying medicines in compliance packs.

'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 many prescriptions. But PIFs were not always attached to prescriptions for part-quantities of medicines, when the pharmacy completed owed prescriptions.

There was a near-miss reporting procedure in place. The near-miss reporting form had changed very recently to help prompt reflection about contributory factors. But contributory factors were not always being completed on the new forms. Pharmacists recorded near-misses following feedback to the member of the team involved. Near-miss reporting had increased significantly since Spring 2019. The RP explained that there was an emphasis on recording every near-miss to support learning. The team explained that changes to staffing during recent months had left one person to cover the medicine counter and dispensary counter sometimes during lunch breaks. This meant the person had to break-off from their work to serve. The team also explained that people visiting the store often asked for help and support from members of the pharmacy team as the prescription and healthcare counters were

prominent features of the store.

The pharmacy reported its dispensing incidents through the 'Pharmacy Event and Incident Reporting System' (PIERS). Incident rates had not risen which showed that pharmacists were picking up on mistakes at the the final accuracy check. The RP explained how she would manage a dispensing incident in accordance with the pharmacy's SOP for incident reporting. Evidence of incident reporting was seen.

The pharmacy team completed monthly Patient Safety Reviews. A pharmacy technician led the reviews. They included trend analysis of near-misses, details of prescribing incidents, dispensing incidents and medicine alerts, such as recalls. The pharmacy team recorded details of actions required to reduce risk during the review. These recently included the importance of staff applying a thorough self-check of their work prior to handing over for the accuracy check and a focus on 'look alike and sound alike' (LASA) medicines, with PIFs used to identify these medicines. The team had implemented several measures to help reduce the number of near-misses involving quantity errors. But these types of mistakes remained the biggest trend. The pharmacy technician was keen to discuss other ideas for reducing this trend. And the inspector shared an example of how another pharmacy had successfully reduced near-misses relating to quantity errors.

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 look to resolve it or escalate it if needed to the manager or RP. The team were aware of how to escalate concerns through to the pharmacy superintendent's team. Pharmacy team members explained how they had used feedback about some missed prescription orders to inform the details of the conversation they had with the person when re-ordering medicines on people's behalf.

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 followed 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 and occasional page headers were not completed. Mistakes in the register were correctly annotated with a dated footnote and explanation. The pharmacy kept running balances in the register. Balance checks of the register against physical stock took place weekly. A physical balance check of MST Continus 10mg complied with the balance in the register. A CD destruction register for patient returned medicines was maintained to date. 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 the details of the prescriber in some entries was not always recorded accurately. The pharmacy team kept records within the register of emergency supplies dispensed. But these did not always include the nature of the emergency when a supply was made at the request of the patient. The pharmacy did not always complete 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 learning following the introduction of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS Information Governance toolkit as required. 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 pharmacy technicians had completed level 2 training on the subject. A pharmacy team member demonstrated records of safeguarding concerns which had been escalated.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people to provide its services. It supports its team members by providing access to continual learning relevant to their role. But some changes within the team has affected the way the team works. The pharmacy has appropriate monitoring systems to manage and review these changes if required. The pharmacy promotes ways in which its team members can provide feedback. And it uses this feedback to inform the safe management of its services. The pharmacy encourages its team members to share learning both within the pharmacy and with other healthcare organisations. And it supports pharmacy professionals in applying their professional judgement in the interests of people accessing its services.

Inspector's evidence

On duty at the time of the inspection was the RP, a pharmacy technician, a pre-registration pharmacist, two qualified dispensers (pharmacy advisors) and a trainee healthcare assistant. The RP was the full-time regular pharmacist, another part-time regular pharmacist was employed, and relief pharmacists covered some weekend hours and bank holidays. The pharmacy also employed another dispenser and a pharmacy technician. The manager was a qualified dispenser, she did not complete any regular tasks in the dispensary. All other members of the team worked across the health and beauty side of the business and did not undertake tasks which required pharmacy training.

Pharmacy team members felt they worked together well as a team. But also felt that workload pressure had increased following changes to some staff roles earlier in the year. Cover for leave was generally provided within the team. But the pharmacy was also able to request support from the relief team if needed. The team explained they were aware of the company reviewing staff training arrangements across stores to help provide additional assistance on busy healthcare counters. No members of the wider store team had yet been enrolled on training to support these new roles.

The pre-registration pharmacist confirmed that she felt well supported, particularly by her pre-registration tutor. She received training time and was aware of how to raise concerns about her training if required. Pharmacy team members had access to ongoing training relating to their roles. The pharmacy manager demonstrated training records which confirmed that mandatory training was up to date for the whole team. Pharmacy team members spoken to, felt supported in their roles and could complete some learning during working hours. Some members of the team explained that they preferred to complete learning at home. A review of training arrangements for one member of the team had taken place following feedback from the team member. Pharmacy team members read information such as ‘professional Standards’ newsletters regularly. They had received some training ahead of a new clinical software programme being installed. Each member of the team received a formal performance review with the manager at least every six-months.

The manager and RP discussed targets in place for providing services. The manager demonstrated how targets were measured through weekly score cards sent to the pharmacy. These were displayed on a staff notice board with areas of ‘praise’ and’ focus’ highlighted. The RP confirmed that she felt able to apply her professional judgement when providing services and was not put under pressure to complete

services because of the targets. The pharmacy technician managing the dispensing of medicines into multi-compartmental compliance packs demonstrated how she had applied her professional judgement to manage risks associated with completing tasks associated with the service.

The pharmacy worked particularly well with a support pharmacist from a nearby surgery. During the inspection pharmacy team members were observed contacting a surgery on a person's behalf as a medicine was unavailable at their wholesalers. The RP supplied her own telephone number to the surgery team to ensure timely communication about the outcome of the intervention, if the pharmacy's phones were busy.

Pharmacy team members communicated through team briefings. Pharmacy team members were briefed individually or in small groups about near-miss and patient safety reviews due to shift patterns. Team members on duty in the dispensary could explain recent actions taken to reduce risk following these reviews. A communication book was in place to help the team in handing information over between shifts.

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 provided examples throughout the inspection of how their feedback was listened to and used to inform service delivery. For example, changes to the lay-out of the dispensary had been trialled and adjusted following a review of working processes. A member of the team explained how the pharmacy shared concerns with other healthcare providers to help inform their learning and improve people's expereinces of their services. For example, feedback had been provided to a surgery about the importance of flagging people who had medicines dispensed in multi-compartmental compliance packs. This was to help ensure that the correct pharmacy received the prescription and the right checks could be applied before supplying medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and is secure to the standard required. It provides a professional environment for the delivery of its services. And it has facilities in place for maintaining the privacy of people accessing these services.

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. The medicine counter and prescription reception counter were busy. Pharmacy team members explained that most people sought out staff at the pharmacy counters for help with finding items in the store and in using the self-service photo machines. The pharmacy had previously had a photography counter on the first-floor level of the premises which had been permanently covered by a member of staff. This area had been re-fitted to provide the separate Medisure room and a manager's office and was now a staff-only area. The dispensary was an adequate size for providing the pharmacy's services. There was also a large stock room and staff facilities on the first-floor level of the premises.

An up-to-date business continuity plan was in place for the pharmacy. 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. Air conditioning was in place. Lighting throughout the premises was sufficient. Antibacterial soap and paper towels were available close to sinks in the dispensary and other staff areas of the premises.

There was a private consultation booth to the side of the medicine counter. It was large enough to accommodate a wheelchair and was signposted. It was professional in appearance and allowed for confidential conversations to take place. A semi-private hatch led from the public area to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services and makes them accessible to people. It demonstrates how people have benefitted from its services. The pharmacy has good records and systems in place to make sure people get the right medicines at the right time. It supplies medicines in devices designed to support people in remembering to take their medicines. The pharmacy gets its medicines from reputable sources. And it stores and manages them appropriately to help make sure they are safe to use. It has some systems in place to provide assurance that medicines are fit for purpose.

Inspector's evidence

The pharmacy had automatic doors which helped people with access. Opening times and details of the pharmacy's services were advertised. The medicine and prescription counters were clearly signposted and visible from the pharmacy's entrance. There was a range of service and health information leaflets available for people to take. Pharmacy team members explained how they would 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.

The RP explained that she enjoyed delivering services. And pharmacy team members helped to identify eligible people for MURs and NMS services during the dispensing process. The RP reflected on some positive examples from the services provided. The pharmacy had some processes in place to identify people taking high-risk medicines. Pharmacy team members attached bright cards to prescriptions to identify additional monitoring checks for paediatric prescriptions, warfarin, methotrexate and lithium. There was evidence of some monitoring checks being recorded on people's medication records after verbal counselling was provided to them. The team was familiar with the requirements of the 'Valproate Pregnancy Prevention Programme' (VPPP). It had completed a valproate audit in 2018. Results of this audit had not identified any people requiring a valproate pregnancy prevention plan. Valproate warning cards were not available at the time of inspection. A discussion took place about the need to issue a warning card every time a prescription for valproate was dispensed to a female within the VPPP target group. Cold chain medicines and CDs were clearly identified. But assembled bags of CDs did not always have a sticker on showing details of the prescription's 28-day validity period. This sticker was designed to inform safety checks at the point of hand-out.

The pharmacy used tubs and trays throughout the dispensing process. This kept medicines with the correct prescription form. Pharmacy team members highlighted tubs and trays holding prescriptions for people physically waiting in the pharmacy. This helped 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 completed relevant sections of 'Quad stamps' on prescription forms. These stamps showed who had assembled, clinically checked, accuracy checked and handed out the prescription. A random check of prescription forms found all sections of the quad stamp completed. 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 kept delivery audit trails for the prescription delivery service. People were asked to sign an electronic device at the point of delivery to confirm they had received their medicine.

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. A pharmacy technician managed the service and other pharmacy team members could support the service if required. The pharmacy technician had implemented a quick reference board in the Medisure room. This allowed members of the team to quickly establish when packs for each person on the service were due. This was in addition to a standard 'Boots Medisure Progress Log' which was used to record details of each stage of the ordering and dispensing process. Each person on the service had their own Medisure record in place. Records were replaced when changes to medicine regimens were applied. Changes and any communication relating to the service was recorded on a duplicate communication form. But forms were not stored with individual Medisure records. The pharmacy technician explained that communication was recorded, and a copy of the communication sheet was provided with the prescription and Medisure record to the pharmacist. Details of the change would also be written on the accompanying PIF. There was no indication on the communication record to confirm that the pharmacist had acknowledged changes. A discussion took place about the advantages of referencing the unique communication sheet number on the Medisure record, if not storing these records together. A sample of assembled packs contained full dispensing audit trails. Descriptions of medicines inside the packs were provided, this meant that people could identify medicines inside the packs. Full dispensing audit trails were in place for the service. 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. Pharmacy team members were aware of the Falsified Medicines Directive (FMD). They could discuss the requirements of the directive but had not completed training associated with changes required to practice. The RP explained that the pharmacy was due to have a new clinical software programme installed within the next few days. The new software was developed with FMD requirements in mind.

The pharmacy stored pharmacy (P) medicines behind the medicine counter. This appropriately protected them from self-selection. It stored medicines in the dispensary in an orderly manner and within their original packaging. Pharmacy team members recorded date checking tasks on a regular basis. A random check of dispensary stock found no out of date medicines. A system was in place for highlighting short-dated medicines. The team annotated details of opening dates on bottles of liquid medicines.

The pharmacy held CDs in secure cabinets. Medicines storage inside the cabinets was orderly. There was a designated area for storing patient returns, and out-of-date CDs within one 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. There was evidence of further checks being carried out if the temperature fell outside of this range. For example, when the door had been left open during cleaning and date checking. The pharmacy held assembled CDs and cold chain medicines in clear bags. This prompted additional checks of the medicines inside prior to hand-out.

Medical waste bins, sharps bins and CD denaturing kits were in place. Some used CD denaturing kits needed transfer from a secure cabinet to the medical waste receptacles provided.

The pharmacy received drug alerts through the intranet. Pharmacy team members explained how they checked stock and recorded any action taken. There were no outstanding alerts waiting for action at the time of inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. Pharmacy team members protect people’s privacy when using the pharmacy’s equipment and facilities.

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. The pharmacy stored assembled bags of medicines waiting for collection and delivery on shelving to the side of the dispensary. It stored prescriptions associated with these bags in a retrieval system, out of sight of people accessing the front prescription counter. The team vigilantly checked information held on the front dispensing bench. They moved documents containing people’s private information before leaving the bench unattended. 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 a separate triangle for use with cytotoxic medicines. Equipment used for dispensing medicines into multi-compartmental compliance packs was single use. Gloves were available if needed. Stickers on electrical equipment showed that safety testing was next due in October 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.