General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 18 High Street, CHIPPING NORTON, Oxfordshire, OX7 5AD

Pharmacy reference: 1035911

Type of pharmacy: Community

Date of inspection: 12/06/2019

Pharmacy context

The pharmacy is located on the high street in the town centre. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs (blister packs) for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse, emergency hormonal contraception (EHC), and seasonal flu vaccination.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy team members are well trained and supported to undertake on-going learning.
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's working practices are safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk well and keeps people's information safely. The pharmacy asks its customers for their views. The pharmacy has written procedures which tell staff how to complete tasks safely. The pharmacy keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

In line with 'patient safety first', near misses were recorded in the near miss incident log and the information was transferred to the near miss incident analysis tool which was divided into time of day, days and weeks 1 to 5. Staff initials were recorded. This was to assist analysis and identify trends in near miss incidents. A monthly patient safety review was prepared, and action points included staff signing to confirm the pharmacist information form (PIF) had been read and increasing the number of near misses recorded. Two incidents of methadone spillage had been documented and reported to head office and the accountable officer.

The model day poster was displayed to assist with time management and when to complete tasks. The prescription accuracy checking tool was displayed where prescriptions were checked. There were defined dispensing and checking areas. 'Lookalike, soundalike' (LASA) medicines laminates and 'select with care' shelf edge labels were displayed to remind staff to take care when selecting medicines. The Professional Standard (PS) was in the process of being read by staff.

Workflow: a legal, clinical and stock check was undertaken on receipt of the prescription. Tubs or trays (for larger numbers of prescriptions) were in use to separate prescriptions and medicines during the dispensing process. Labels were generated, and medicines were picked from reading the prescription. Special messages were recorded on the pharmacist information form (PIF) including high-risk medicines, owing medication or interactions. Laminated cards were added to the tub/tray to highlight high-risk medicines such as paediatric medicines, fridge item or controlled drugs (CDs).

There were separate dispensing and checking areas. The dispensing audit trail was completed after the final check of medication by the pharmacist prior to transfer to the patient. The four-way stamp was initialled by staff identifying who dispensed, checked and handed out the prescription. Filed prescriptions awaiting collection included the PIF and laminated card to prompt counselling when the prescription was collected.

There was shelving to store part completed prescription tubs and prescriptions awaiting final check by the pharmacist. Posters relating to NICE guidelines for sodium valproate and isotretinoin were displayed for staff reference in the dispensary.

There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For "manufacturer cannot supply" items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance packs (blister packs) were prepared for a number of patients in a separate area away from the dispensary to provide more space and reduce distraction. Blister packs were prepared on a rolling basis and one week in advance of supply date to manage any problems with stock or prescriptions. The pharmacy managed prescription re-ordering on behalf of patients.

There was a folder where each patient had a Medisure patient record which included their communication record, discharge summaries, notes and information on their medicines. Medisure records were re-written when there was a change to medication. A record was maintained of prescription requests, collection of blister packs and signature of the patient or representative. Messages were recorded on the patient medication record (PMR) and in the communications book. There was a poster of patient safety tips to follow on display.

Labelling included a description to identify individual medicines and patient information leaflets (PILs) were supplied with each set of blister packs. High-risk medicines such as alendronate and sodium valproate were supplied separately from the blister pack. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. Special instructions relating to taking medicines such as levothyroxine were highlighted on labelling. Duplicate labels of medicines supplied separately in original packaging such as inhalers were not attached to the exterior of the blister pack to remind patients to use them.

Staff were up to date with training in standard operating procedures (SOPs) the latest of which had been core SOPs. A staff member, handing out a prescription, was observed confirming patient name, address and post code and ticking the bag label in line with the handing out SOP. The medicines counter assistant (MCA) explained that she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. A staff member was observed asking WWHAM questions in response to a request for anti-fungal cream. The practice leaflet was on display and details of how to comment or complain. The Community Pharmacy Patient Questionnaire (CPPQ) to obtain feedback from members of the public was current.

To protect patients receiving services, there was valid professional indemnity insurance in place. The responsible pharmacist notice was on display and the responsible pharmacist log was completed along with fridge temperatures and CD key log. Records for private prescriptions, emergency and special supplies (most recent dated 2017) were complete. There was a prescription for more than one month's supply of a controlled drug (CD) as good practice for which no intervention had been recorded on the PMR. There was a discussion about recording of interventions to ensure staff and other pharmacists knew what had been discussed and agreed with other healthcare professionals. The patient group direction (PGD) for EHC (13-21 years of age) was in date and signed by the pharmacist.

The CD registers were generally complete, and the balance of CDs was audited weekly in line with the SOP. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were signed and dated. The supplier name and invoice number were recorded but not the supplier address for receipt of CDs. There was a discussion about a register for a form of methylphenidate which was a single photocopied sheet stapled to a blue divider and both were at risk of becoming detached and mislaid.

Patient returned CDs were recorded in the destruction register for patient returned CDs. All the headers in the methadone register were not completed and there were loose sheets which had become detached from the register and may have been at risk of being mislaid. Footnotes correcting entries were not all signed and dated. The supplier name and invoice number were recorded but not the supplier address for receipt of CDs. The quantity of methadone was audited regularly. FP10MDA prescriptions were endorsed at the time of supply.

Staff had signed confidentiality agreements and had completed eLearning regarding information governance (IG) and General Data Protection Regulation (GDPR). Confidential waste paper was collected for safe disposal including in the blister pack preparation area and a cordless phone to enable a private conversation. Staff generally used their own NHS cards. There was a 'Fair data processing' notice displayed in the public area. NHS leaflets 'Your data matters to us' were displayed. Staff had undertaken safeguarding and dementia friends training and pharmacists were accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and works well together. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one part-time pharmacist, one full-time trainee pharmacy technician, two dispensers (one full-time and one part-time also accredited as medicines counter assistants (MCAs)), two part-time MCAs and one full time trainee MCA. There was one full-time staff vacancy which was covered by the trainee pharmacy technician. There were three other staff. Deliveries were by Boots PDC trained staff.

Staff were provided with Tutor packs every three months which were studied at home while eLearning was completed at work. Tutor packs included new product information for instance Spatone and health related items such as infant feeding. Staff were required to complete mandatory training every three months and topics included health and safety, fire safety and harassment. Training included new SOPs and staff described the SOP for transfer of medicines to the patient which had been updated to include initialling the bag label at the point of transfer. There was a quiz to test knowledge and understanding of the topic. The 'Health CARE Way' was a revision topic. To meet quality payments criteria, staff had trained in children's oral health and risk management.

There was a system of staff appraisal and review of performance which were documented. Staff were free to provide feedback to improve services and had suggested bringing completed blister packs due for collection from the preparation area to be stored in retrieval until the patient or representative visited the pharmacy to collect. There was a whistleblowing policy. The company organised 'Let's Connect' events for pharmacists and pharmacy technicians where the agenda included continuing professional development topics and company updates. The regular pharmacist was attending the event on the day of the visit. Targets and incentives were set but staff did not believe patient safety and wellbeing was adversely affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and suitable for the provision of its services.

Inspector's evidence

The pharmacy premises were clean, tidy and well presented. There were two chairs in the waiting area. The dispensary benches were clean and clear. The dispensary sink required treatment to remove lime scale. Lavatory facilities were clean and handwashing equipment was provided. There was a handwashing facility in the blister pack preparation area.

The consultation room was locked when not in use and patient privacy was protected. The consultation room was located in the store which had secure access via keypad. There was sufficient lighting and air conditioning including in the blister pack preparation area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was wheelchair access via double automatic door to assist people with mobility aids. Large font labels could be printed to assist patients with impaired vision and there was a hearing loop to assist hearing impaired people. The pharmacy had healthy living status.

Patients were signposted to other local services including the optician for minor eye conditions, out of hours service and paramedics at the local health centre. Interventions were generally recorded on the PMR. The INR was recorded on the PMR for people who were prescribed warfarin.

In line with information requested via the laminated cards, people taking warfarin were asked about blood test dates and for their record of INR which was recorded on the PMR. The dose of the warfarin and the time to take the dose was explained. Advice was given about side effects of bruising and bleeding. Advice was given about diet containing green vegetables which could affect INR.

People taking methotrexate were reminded of the weekly dose and taking folic acid on a different day and asked the date of the last blood test. Advice was given to visit the doctor if sore throat or fever developed. People taking isotretinoin were advised about the pregnancy prevention programme (PPP) and asked to confirm they had had a negative pregnancy test. Isotretinoin prescriptions were dispensed within seven days of issue.

Regarding supply of sodium valproate, there was information and cards to distribute to patients in the at risk group. The regular pharmacist was not present to provide information on audits, but the staff present related that there were no people who may become pregnant who were supplied sodium valproate.

In the health zone beside the dispensary, there were posters and information to raise public awareness and included stop smoking, 'Smile 4life' (in line with children's oral health), suicide and cervical screening. There were leaflets on children's mental health and dementia. The NHS email and nhs.uk entry was current. Falsified medicines directive (FMD) hardware and software was not operational at the time of the visit.

Medicines and medical devices were delivered outside the pharmacy by Boots PDC trained drivers. Signed delivery logs were seen. Medicines and medical devices were obtained from Alliance, AAH and Phoenix. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date-checked and recorded. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening. Medicines were stored in original manufacturer's packaging.

Cold chain items were stored in the medical fridge. There was very little cold chain stock following a recent fridge failure which had been dealt with. Waste medicines were stored separately from other stock and there was a pharmaceutical waste bin in the blister pack preparation area.

Uncollected prescriptions were removed from retrieval every 4 weeks. CD prescriptions were highlighted with a CD sticker and the PIF was endorsed to ensure supply within 28-day validity. Five patients accessed the substance misuse service. Drug alerts were printed, actioned, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current reference sources included Medicines Complete, BNF and Drug Tariff. There was a range of British standard glass measures to measure liquids including separate marked measures for methadone. Measures required treatment to remove lime scale. There was a sharps bin in the consultation room which was locked. Minimum and maximum fridge temperatures were monitored daily and found to be within range 2□-8□. The CD cabinet was fixed with bolts. There were CD destruction kits.

Staff had signed confidentiality agreements and had completed eLearning regarding information governance (IG) and General Data Protection Regulation (GDPR). Confidential waste paper was collected for safe disposal including in the blister pack preparation area and a cordless phone to enable a private conversation. Staff generally used their own NHS cards. There was a 'Fair data processing' notice displayed in the public area. NHS leaflets 'Your data matters to us' were displayed.

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.