General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 11 Bridge Street, STRATFORD-UPON-AVON, Warwickshire, CV37 6AB

Pharmacy reference: 1037838

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

This is a community pharmacy located in the centre of the historic town of Stratford-upon-Avon in Warwickshire. The pharmacy dispenses NHS and private prescriptions. It offers Medicines Use Reviews (MURs), the New Medicine Service (NMS), seasonal flu vaccinations and delivers medicines. The pharmacy also supplies medicines inside multi-compartment compliance packs if people find it difficult to take their medicines on time. And it provides medicines to residents in care homes.

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	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 ensures its services are provided safely. The team makes appropriate clinical checks for people. This includes people prescribed higher-risk medicines, and there are audit trails to verify this.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Overall, the pharmacy manages the risks associated with its services in a suitable manner. The pharmacy protects people's private information appropriately. The team understands how to protect the welfare of vulnerable people. And, the pharmacy adequately maintains the records that it is required to keep. Members of the pharmacy team largely monitor the safety of their services by recording their mistakes and learning from them.

Inspector's evidence

A steady stream of people used the pharmacy's services during the inspection. This was managed appropriately by the team but there were limited numbers of staff present (see Principle 2). The pharmacy was up to date with the workload and the responsible pharmacist (RP) explained that the pharmacy had become busier since the coronavirus outbreaks. This included dispensing prescriptions and requests for the flu vaccine (see Principle 4), sales of hand sanitisers as well as painkillers. The pharmacy had sold out of the latter two. The pharmacy's dispensing activity took place in three separate areas. This included the main dispensary situated downstairs, medicines were assembled into multi-compartment compliance packs and prepared from a dispensary upstairs and the third dispensary was used to assemble prescriptions for residents in care homes. The latter two dispensaries were in an area that was not accessible to the public. This helped to minimise the likelihood of errors happening and reduced distractions.

In the main dispensary, the workflow involved the bulk of the walk-in prescriptions being dispensed on the front bench. To maintain people's privacy, staff explained that they moved computer screens to ensure details on them were not visible or unauthorised access possible. Confidential information was kept hidden out of sight and placed under a ledge and staff used the enclosed section of the front bench as much as possible. There was no confidential information left in areas that were accessible to the public. Sensitive details on dispensed prescriptions that were awaiting collection could not be seen from the retail space. Confidential waste was placed into designated bins and disposed of through the company's procedures. Summary Care Records had been accessed for emergency supplies and verbal consent for this was obtained from people. However, there was no notice on display to inform people about how the pharmacy maintained their privacy.

The team attached the company's pharmacist information forms (PIFs) to prescriptions so that relevant information could be easily identified. Staff routinely recorded their near misses, they were collectively reviewed every month and the company's 'Patient Safety Review' (PSR) was completed and used to assist with this. The team was briefed every month about common mistakes, on a one to one basis by the patient safety champion. There were separate near miss logs used for each of the different dispensaries. However, the near miss records in the main dispensary downstairs had gaps within the 'comments' section which could have provided details about the root cause of people's mistakes. Staff had begun to fully complete this section in the records located upstairs and the store manager explained that this had recently been identified as an area for improvement. This was communicated to the team in the dispensary during the inspection. The store manager and pharmacists handled incidents. Their procedure was in line with the company's documented complaints policy. There was information on display seen in the retail area to inform people about the pharmacy's complaints procedure.

Staff could identify signs of concern and groups of people that required safeguarding. The RP would be informed in the first instance. Team members had completed training through the company's e-Learning module and been briefed about this by the pharmacists. The procedure to follow with contact details for the local safeguarding agencies were present and the RP was trained to level two via the Centre for Pharmacy Postgraduate Education.

Team members understood their responsibilities. The correct RP notice was on display and this provided details of the pharmacist in charge of operational activities on the day. The pharmacy held a range of documented standard operating procedures (SOPs) to cover the services that it provided. They were dated from 2018 to 2019. Roles and responsibilities of the team had been defined within them and staff declarations were complete to state that they had read the SOPs.

The pharmacy's records were generally maintained in line with legal requirements. The records checked included the RP record, registers for controlled drugs (CDs), records about unlicensed medicines, emergency supplies and private prescriptions. The nature of the emergency was missing occasionally for records about emergency supplies and on occasion, staff had recorded incorrect prescriber's information within the electronic register for private prescriptions. A private prescription for a CD from February 2020 had not been submitted to the NHS Business Services Authority and the RP was unaware of the need to do so, although the store manager did know this. This was discussed with the RP at the time. Balances for CDs were checked and documented every week. On randomly selecting some CDs that were held, their quantities corresponded to the balances stated in registers. The minimum and maximum temperature of the fridge was monitored daily. This helped to ensure that temperature sensitive medicines were appropriately stored, and records had been maintained to verify this. The pharmacy maintained a complete record for the receipt and destruction of CDs that had been returned by people for disposal. The pharmacy held appropriate professional indemnity insurance to cover the services provided.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members understand their roles and responsibilities. They are suitably trained for their roles or are undertaking appropriate training. And the company provides them with resources to keep their skills and knowledge up to date. Overall, the pharmacy has adequate numbers of staff to manage its workload. But it doesn't always have sufficient contingency arrangements to cover unplanned absence. And staff sometimes struggle to complete their course material at work. So, they may not be able to finish this in a timely manner.

Inspector's evidence

Staff present during the inspection consisted of the RP and two part-time pharmacy advisers in the main dispensary. The store manager and one other part-time pharmacy advisor were managing the workload for the care homes and one part-time pharmacy advisor was responsible for preparing medicines into the compliance packs for people in their own homes.

The team covered each other as contingency for absence or annual leave. However, at the point of inspection, two full-time members of staff were absent, and staff based upstairs covered the dispensary as well as the medicines counter downstairs during the lunch period. This left limited members of staff to manage the workload. The pharmacy was up to date with this; the store manager explained that the team was only focusing on interims and acute medicines for the care homes on the day of the inspection to help manage the workload. The team was up to date with the pharmacy's routine tasks. However, staff in training explained that for the past three weeks, they had not been provided with set-aside time to complete their course material because of the reduced numbers of staff. They had found it difficult to complete this at home. When asked about the staffing profile, the store manager said that the pharmacy had the required numbers of staff in line with its volume of workload.

Staff wore name badges. They confirmed that they had completed their training through accredited routes but their certificates of qualifications were not seen. Team members provided advice and asked appropriate questions before they sold medicines over the counter, they referred to the RP when required. Staff described the company providing them with e-Learning modules, newsletters and SOPs. They were up to date with the company's mandatory training. Weekly team meetings took place to keep the team informed about relevant updates. Formal appraisals were held regularly to check the team's progress. The RP explained that she had not been set any formal targets yet to complete services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an adequate environment to deliver its services. The pharmacy is clean.

Inspector's evidence

The pharmacy premises consisted of a medium-sized retail area and small dispensary at the rear on the left-hand side of the entrance. Medicines for the care homes were assembled from a large and spacious dispensary situated upstairs with a medium-sized dispensary used to assemble medicines into compliance packs. There was plenty of space upstairs for dispensing activity to take place safely and an adequate amount of space downstairs. The dispensary in the latter was quite cluttered initially although this was cleared during the inspection. The pharmacy was clean and well ventilated. Overall, the retail space was suitable in its appearance. However, the pharmacy area in the retail space was quite dim. There were four lights here that were not functioning, and staff explained that they had not noticed as they had become used to this. This however, gave out the appearance that the dispensary was closed and could pose health and safety concerns for the team members. This was discussed with the store manager at the time.

A signposted consultation room was available for services and private conversations. This was kept unlocked as the lock had broken. The RP stated that this had been reported to the company's maintenance department. The space was of an adequate size. There was no confidential information present. A curtain could be drawn across to protect people's privacy. However, there was no roof to this space and the room was located next to the seating area for people. There was a risk that confidential conversations could have been overheard. The RP explained that staff spoke in lowered tones in this area to help mitigate this risk. Pharmacy (P) medicines were stored behind the front pharmacy counter. There was no barrier available to restrict people's entry into the dispensary or behind the counter. Staff were generally within the vicinity to help prevent P medicines from being self-selected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. Its team members take extra care with higher-risk medicines. They ask about relevant information when people receive these medicines and record the details. This helps them to show that appropriate advice has been provided upon supply. The pharmacy obtains its medicines from reputable sources. It stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had an automatic door at the front of the store. This, coupled with the wide aisles and clear, open spaces inside the premises, enabled people with wheelchairs, pushchairs or restricted mobility easy access to the pharmacy's services. Two seats were available for people waiting for prescriptions. Staff described physically assisting people who were visually impaired. They used written information for people who were partially deaf or faced them so that they could lip-read. A hearing-aid loop was also present but not all the team members knew how to use this. Google translate was used to help communicate with people whose first language was not English and some of the team spoke Romanian as well as Russian. The pharmacy's opening hours were on display. The team could use documented information to signpost people to other local organisations.

The pharmacy used plastic tubs to hold prescriptions and items during the dispensing process. This helped prevent their inadvertent transfer. A dispensing audit trail from a facility on generated labels as well as a quad stamp assisted in identifying staff involved. Dispensed prescriptions awaiting collection were stored within an alphabetical retrieval system. Fridge items and CDs were placed into clear bags once they were assembled, this helped to identify them more easily when they were handed out.

The team used laminated cards, stickers and PIFs to highlight relevant information such as CDs (Schedules 2 to 4), fridge and higher-risk medicines. Staff checked relevant information for the latter, such as asking about the dose, strength and blood test results. They also recorded and retained these details. This included information for residents in the care home that had been prescribed higher-risk medicines. Staff were aware of the risks associated with valproates and an audit had been completed to help identify people at risk. The pharmacy had relevant educational material available to provide to people at risk upon supply of these medicines. The pharmacy had also completed audits to identify whether people prescribed lithium had been monitored appropriately or people with diabetes had been receiving the appropriate checks for their feet and eyes. The store manager explained that this had not always happened for the latter and they were signposted appropriately.

Medicines inside compliance packs were supplied once people's suitability for them was assessed by the pharmacists. The pharmacy ordered prescriptions on behalf of people and staff cross-referenced details on prescriptions against individual records. This helped them to identify any changes and records were maintained to verify this. All medicines were de-blistered into the compliance packs with none supplied within their outer packaging. They were not left unsealed overnight when assembled. Descriptions of medicines were provided and patient information leaflets (PILs) were routinely supplied. People prescribed warfarin and methotrexate who received compliance aids were supplied these medicines separately. Mid-cycle changes involved the compliance packs being retrieved and new ones were supplied.

Staff supplied medicines to the care homes as either original packs of medicines or as compliance packs. Once the care homes had requested prescriptions, a duplicate copy of the Medication Administration Record (MAR) detailing the requests was provided and prescriptions were checked against this to ensure all items had been received. A missing items form was faxed to the care home if items were outstanding. Interim or mid-cycle items were dispensed at the pharmacy. The team obtained information about allergies and recorded this on MAR charts. PILs were routinely supplied. Staff had been approached to provide advice regarding covert administration of medicines to care home residents and they maintained documented details to verify this. A three-way conversation and agreement were required between the pharmacy, care home or representatives and the person's GP. Relevant guidelines and resources were used to assess the suitability for this.

The pharmacy provided a delivery service and it maintained audit trails to verify this. CDs and fridge items were highlighted. The company's drivers obtained signatures from people when they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy with notes left to inform people about the attempt made. The pharmacy did not leave medicines unattended.

The RP explained that the influenza vaccination service was popular, and that people had started requesting this again recently. They were explained that this would not assist them against coronavirus. The pharmacist worked to defined procedures; the SOP for the service was present, informed consent was obtained, a risk assessment was carried out and relevant paperwork under the Patient Group Direction (PGD) that authorised this, was signed and readily accessible. The consultation room was used to provide this service and relevant equipment to ensure the vaccination service took place safely was available. This included adrenaline ampoules and a sharps bin. The RP was confident to administer adrenaline ampoules in the event of an emergency. Posters and notices were on display to provide advice about coronavirus.

The pharmacy used licensed wholesalers such as Alliance Healthcare, AAH and Phoenix to obtain medicines and medical devices. Unlicensed medicines were received from Alliance Specials. Staff were unaware about the processes involved for the European Falsified Medicines Directive (FMD). There was no relevant equipment on site or guidance information present for the team and the pharmacy was not yet complying with FMD at the point of inspection.

Medicines were stored in an organised manner and there was a date-checking schedule to verify that this process had been taking place. Staff used stickers to highlight short-dated items. Liquid medicines were marked with the date upon which they were opened. CDs were stored under safe custody and the keys to the cabinet were maintained in a manner that prevented unauthorised access during the day as well as overnight. A CD key log had been completed as an audit trail to verify this. Medicines returned for disposal, were accepted by staff and stored within designated containers. There was a list available for the team to identify hazardous and cytotoxic medicines that required disposal and designated containers to store them. People returning sharps for disposal, were referred to the local council. Returned CDs were brought to the attention of the RP and separated in the CD cabinet before their destruction. Relevant details were noted. Drug alerts were received through the company system, the team checked for affected stock and acted as necessary. An audit trail was present to verify the process. Staff described checking records to see if any affected batches had been supplied and informed the care homes if this had happened.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. Its equipment is kept clean.

Inspector's evidence

The pharmacy held current versions of reference sources and staff could use online resources. The CD cabinet was secured in line with the legal requirements and the medical fridge was operating at appropriate temperatures. There was a range of standardised, conical measures available for liquid medicines, designated measures used for methadone and counting triangles present. The sinks in the dispensaries used for reconstituting medicines were clean. Antibacterial hand wash and hot as well as cold running water was available. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. Cordless phones were available to maintain private conversations. Staff held their own NHS smartcards to access electronic prescriptions and took them home overnight.

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.