General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Westgate House, 1 Market Street, WARWICK, Warwickshire, CV34 4DH

Pharmacy reference: 1037854

Type of pharmacy: Community

Date of inspection: 28/01/2020

Pharmacy context

This is a community pharmacy located in the centre of the market town of Warwick in Warwickshire. The pharmacy dispenses NHS and private prescriptions. It sells a range of over-the-counter (OTC) medicines and delivers medicines. And it offers a few services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS) and seasonal flu vaccinations.

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	1.2	Good practice	The pharmacy routinely monitors the safety and quality of its services. Staff regularly record, review and discuss incidents. This helps them to effectively learn from their mistakes.
2. Staff	Good practice	2.2	Good practice	The pharmacy's team members have the appropriate skills, qualifications and competence for their role and the tasks they carry out. The team ensures that routine tasks are always completed so that the pharmacy operates in a safe and effective manner.
		2.4	Good practice	The pharmacy has adopted a culture of openness, honesty and learning. The company provides resources to ensure the team's knowledge is kept up to date. And some members of the team monitor the team's training. This helps improve their knowledge as well as ensuring they routinely work in line with the pharmacy's standard operating procedures.
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 effectively managed so that they 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

The pharmacy is operating safely. Overall, its team members work in line with the written procedures set by the company. Members of the pharmacy team regularly monitor the safety of their services. They record their mistakes and learn from them. The team understand how to protect the welfare of vulnerable people. The pharmacy protects people's private information well. And most of its records are maintained in accordance with the law.

Inspector's evidence

The pharmacy was organised, clean and tidy. Its workspaces were clear of clutter. 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. Staff had read and signed the SOPs. They knew their responsibilities and the tasks that were permissible in the absence of the pharmacist. The team's roles were also defined within the SOPs. The correct responsible pharmacist (RP) notice was on display and this provided details of the pharmacist in charge on the day.

The workflow involved the bulk of prescriptions being processed and dispensed on the front bench. The former activity took place from one section of the front bench which was enclosed to the public. To maintain people's privacy, staff explained that they kept confidential information hidden out of sight and showed people details rather than discussing them out loud if they could. 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 segregated into designated bins and then disposed of through the company's procedures. There was a notice on display to inform people about how the pharmacy maintained their privacy and the consultation room was routinely used for private conversations and services. The RP described accessing Summary Care Records for emergency supplies or for queries. Consent for this was obtained verbally from people and details recorded.

To help minimise errors from distractions, staff dispensed one person's prescription at a time. The team attached the company's pharmacist information forms (PIFs) to all prescriptions so that relevant information could be easily identified. The RP accuracy-checked prescriptions from a designated area. Staff routinely recorded their near misses and they were collectively reviewed every month. The company's Patient Safety Review was used to assist this process. The team was briefed about common mistakes every month. Since the pharmacy had implemented a new system, the team's near misses had reduced. This was because, upon selecting and scanning an incorrect medicine, the pharmacy system picked up and highlighted this before medicines were dispensed. Staff had identified trends with quantities, they had focussed on this and tried to minimise mistakes by writing the quantity that they had counted on the inside of the packaging. This served as a double-check and informed the RP that this process had been carried out.

The pharmacy technician was the patient safety champion and described the team currently focusing on children's medicines. This was to help reduce errors when prescriptions were seen for these medicines. Relevant literature was provided through the company and this was discussed with as well as highlighted to team members. In addition, a folder had been created with additional information. Staff were asked to read this and to help understand the various processes, quizzes were held and

discussed with the team to facilitate their learning.

Incidents were handled by the RP. The procedure for this was in accordance with the company's expectations. There was information on display in the retail area to inform people about the pharmacy's complaints procedure. The RP explained that in response to previous hand-out errors, the pharmacy had implemented the company's two step process for handing out prescriptions. This involved people's addresses being initially checked and then once the dispensed prescription had been located, staff confirmed people's postcodes.

Staff could identify groups of people who might require safeguarding and signs of concern. The RP would be informed in the first instance. Staff had been trained through reading relevant information and completing an e-Learning module. The procedure to follow with relevant and local contact details were present and the RP was trained to level two via the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy's chaperone policy was also on display.

The team kept daily records of the minimum and maximum temperatures for the fridge and this verified that medicines were stored here appropriately. Staff also maintained a complete record of controlled drugs (CDs) that had been returned by people and destroyed by them. The pharmacy's professional indemnity insurance was in place. Most of the pharmacy's records were fully maintained in line with statutory requirements. This included a sample of registers seen for CDs, the RP record and records of emergency supplies in general and unlicensed medicines. For CDs, balances were checked and documented every week. On randomly selecting CDs held in the cabinet, the quantities held matched the balances within the corresponding registers. There were occasional over-written entries in the RP register and the RP had signed out before her shift had finished. Occasional records of emergency supplies were not recorded with enough information to help justify the supply. Team members were also recording incorrect prescriber information for some entries within the electronic private prescription record. Ensuring the pharmacy's record keeping routinely complied with legal requirements was discussed during the inspection.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are suitably trained or undertaking the appropriate training. The company provides them with a range of resources as part of their ongoing training. And some members of the team have taken further ownership to ensure the team is fully informed about the pharmacy's internal processes. This has created a suitable environment for learning and helps keep the team's skills and knowledge up to date.

Inspector's evidence

At the time of inspection, there were two trained dispensing assistants, a pharmacy technician, a pre-registration trainee and the regular pharmacist. The latter was also the store manager. Staff wore name badges outlining their roles, they asked relevant questions before they sold over-the-counter (OTC) medicines, provided advice and checked with the RP appropriately. The team's certificates to verify their qualifications obtained were not seen although their competence was demonstrated during the inspection. Staff had the confidence to raise any concerns that they may have had, and the company's whistle-blowing policy was easily accessible.

The pre-registration trainee was provided with set-aside time to study and the RP was their designated tutor. She felt supported and was familiar with her training plan. To assist with ongoing training needs, the company provided staff with e-Learning modules and tutor packs that were combined with quizzes about SOPs. In addition to the patient safety champion's quizzes (as described in Principle 1), every week a huddle was held to learn about the SOP for that week. Team members talked through the process so that they could learn and better understand how this could be implemented. Staff progress and appraisals were conducted quarterly. They were a small team and communicated verbally. There were also noticeboards, newsletters, emails and trade publications used to keep them informed and the store manager provided relevant information via small groups. The RP described various targets in place to complete Medicines Use Reviews (MURs), the New Medicine Service (NMS) and flu vaccinations. The pharmacist was enthusiastic about the services (see Principle 4). The targets were described as manageable with no pressure applied to complete them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for the delivery of healthcare services. The pharmacy is clean. And it has a private area where conversations and services can take place.

Inspector's evidence

The pharmacy premises consisted of a medium-sized retail area and dispensary at the very rear. The latter was made up of a front work bench which contained an enclosed unit. The rest of the dispensary was also enclosed and there was enough space to carry out the pharmacy’s dispensing activities safely. The pharmacy was clean. It was professional in its appearance. The pharmacy was also appropriately lit and well ventilated. Pharmacy (P) medicines were stored behind the front pharmacy counter and staff were always within the vicinity to help prevent these medicines from being self-selected. A signposted consultation room was available for private conversations or services. The room was of an adequate size for its intended purpose. The door was kept closed but unlocked, there was no confidential information accessible and a curtain could be pulled across the door to maintain people’s privacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services in a safe and effective manner. Its services are easily accessible. The pharmacy's team members actively promote healthier living. They take extra care for people prescribed higher-risk medicines. This helps ensure that people can take their medicines safely. The pharmacy obtains its medicines from reputable suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

People could access the pharmacy's services through wide, automatic front doors at street level. The premises consisted of clear open space, wide aisles and there was a lowered counter at one end of the dispensary counter. This helped people with wheelchairs to use the pharmacy's services easily. There were four seats available for people waiting for prescriptions. A hearing aid loop could be used for people who were partially deaf, and staff described facing them so that they could easily lip -read and used written communication. They physically assisted people who were visually impaired and read details to them. Staff also spoke Chinese and South Asian languages such as Punjabi to assist in communicating with people whose first language was not English.

During the dispensing process, the team used tubs to hold prescriptions and medicines and this helped to prevent the inadvertent transfer of items. A dispensing audit trail was used to identify the staff involved. This was through a facility on generated labels and a quad stamp on prescriptions. Dispensed prescriptions awaiting collection were stored within an alphabetical retrieval system. The team identified fridge items, CDs (Schedules 2-3) and when pharmacist intervention was required with stickers, PIFs and laminates. Clear bags were used to hold assembled fridge items and CDs. This assisted in identifying the contents when they were handed out to people. Schedule 4 CDs were not routinely identified in the retrieval system although uncollected prescriptions were checked every week and removed every four weeks. Implementing this to help identify their 28-day prescription expiry as best practice was advised during the inspection. However, staff had also implemented an additional check whereby they checked the electronic prescription system every week for dispensed prescriptions. People who hadn't collected their prescription were then texted to make them aware and this helped ensure any outstanding prescriptions were processed appropriately.

Licensed wholesalers such as Alliance Healthcare, AAH and Phoenix were used to obtain medicines and medical devices. Unlicensed medicines were obtained from Alliance Healthcare. Staff held some awareness of the process involved for the European Falsified Medicines Directive (FMD), but the pharmacy was not yet complying with the decommissioning process. The pharmacy's stock was organised. Medicines were date-checked in sections and the team used a date-checking schedule to verify when this process had been carried out. In addition, staff had also created a laminated board for reference so that they could track when each section of medicines had been date-checked and by whom. Short-dated medicines were identified using stickers. Liquid medicines were marked with the date upon which they were opened and there were no date-expired medicines or mixed batches seen. Medicines were stored evenly in the fridge. CDs were stored under safe custody and keys to the cabinet were maintained in a manner that prevented unauthorised access during the day as well as overnight. Drug alerts and product recalls were received through the company, stock was checked, and action taken as necessary. The pharmacy kept an audit trail to verify this.

Medicines returned for disposal, were accepted by staff and stored within designated containers. However, there was no list available for the team to identify hazardous and cytotoxic medicines that required disposal and no designated containers to store them. This was discussed at the time. After making the relevant checks, the RP provided information following the inspection and stated that the pharmacy did not have a contract to accept hazardous and cytotoxic medicines. A list had been implemented and the team would be referring people going forward. Sharps returned for disposal, were accepted provided they were contained within the appropriate sealed containers. Returned CDs were brought to the attention of the RP and segregated in the CD cabinet before their destruction. Relevant details were entered into a CD returns register.

The pharmacy was Healthy Living accredited. There was a dedicated zone in one area of the retail space along with an additional space that had been created by the team. The former was used to promote campaigns in line with the national ones and staff used the latter to help bring awareness of topics that met local needs. Both held leaflets and displayed posters, but the latter section was more bespoke and included material that had been specifically created by the team. This included a set of teeth which were used by people and children to help them learn how to brush their teeth appropriately. The current campaign was promoting alcohol awareness. In the past, staff described providing advice on incontinence and had displayed open packs of products so that people could easily see the differences between them. The team kept photographic evidence of the campaigns that had been held previously. Staff signposted people to other local services from their own knowledge of the area, from online resources, documented information that was present and there were also relevant contact details on display in the dispensary.

The RP described the NMS service being beneficial as this had enabled people to be monitored when they were prescribed new medicines. The RP had provided reassurance, discussed side effects and encouraged people to continue when they had asked to stop taking their medicine(s) early on in their treatment. Some people had also continued to call the pharmacist for advice, information and support after the service had been concluded.

The pharmacy provided a delivery service and the team retained audit trails for this. CDs and fridge items were highlighted. People were called first to confirm that they would be home. The driver obtained people's signatures when they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and medicines were not left unattended.

The pharmacy also provided a repeat prescription ordering and management system. Written consent was obtained from people initially when they signed up to this service. Staff ordered prescriptions for people on their behalf by checking the medicines that were required for the following month. This took place when they handed out dispensed prescriptions. Details were ticked on the repeat slips by the person, staff queried with them if routine medicines had not been requested. There was also a lockable filing cabinet used to store the repeat prescriptions and a notice on display to inform people when their next prescription was due.

The team was aware of the risks associated with valproates during pregnancy. There was also guidance material available to provide to people at risk. Audits had been completed in the past but no-one at risk had been identified as having been supplied this medicine. People prescribed higher-risk medicines were routinely identified, counselled and relevant parameters were checked. This included checking the International Normalised Ratio (INR) levels for people prescribed warfarin and asking about blood test results. The pharmacy team routinely recorded details to verify this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has an appropriate range of equipment and facilities to provide its services safely. They are used in a way to help protect people's privacy

Inspector's evidence

The pharmacy held an appropriate range of equipment and facilities that it needed for its services. This included current reference sources, access to online reference databases, a range of standardised conical measures for liquid medicines, counting triangles and a separate one for cytotoxic medicines. The CD cabinet was secured in line with statutory requirements and the medical fridge was operating within the appropriate temperature range. The dispensary sink used to reconstitute medicines was clean. There was hand wash and hot as well as cold running water available. Staff could store their personal belongings in lockers. The pharmacy's computer terminals were password protected and positioned in a manner that prevented unauthorised access. Staff used their own NHS smart cards to access electronic prescriptions and they 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.