General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 25-26 Market Place, DUDLEY, West Midlands, DY1 1PJ

Pharmacy reference: 1038340

Type of pharmacy: Community

Date of inspection: 24/04/2019

Pharmacy context

The high street pharmacy is located in Dudley town centre. The pharmacy provides a range of services including: a repeat prescription collection and delivery service, medicines dispensed in multi-compartment compliance aids for a number of community patients, supply of medication to residents in a number of care homes, supply of clozapine to community patients, medicines use reviews, new medicine service, flu vaccinations, the provision of substance misuse treatment services, free emergency hormonal contraception and a text messaging service. There were two relief pharmacists present and there is usually a pharmacy manager who works in the pharmacy.

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	Pharmacy team members consistently record and review their mistakes, so that they can learn from them and act to reduce future risk.
		1.7	Good practice	Pharmacy team members receive regular training, so that they know how to handle patient information safely and securely.
2. Staff	Good practice	2.2	Good practice	Members of the pharmacy team are supported with ongoing training to help them keep their knowledge up to date.
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

Members of the pharmacy team follow written instructions to help them work safely and effectively. They record mistakes they make so that they can learn from them. People who work in the pharmacy get regular training to make sure that they know how to keep private information safe.

Inspector's evidence

A full range of up-to-date standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. They were reviewed on a rolling basis. All members of staff read and signed the SOPs relevant to their role e.g. there were specific SOPs for those working in the care homes and room for assembling multi-compartment compliance aids. Roles and responsibilities of staff were highlighted within the SOPs.

Near miss logs were in regular use and incidents were logged and reviewed for the different areas within the pharmacy business e.g. for care homes, multi-compartment compliance aids and for walk-in prescriptions and repeat collection prescriptions. Where possible, the staff member involved was responsible for correcting and recording their own error to help ensure they learnt from their mistake. An accuracy checking technician (ACT) said that there had been a few occasions when near misses had occurred where she had found MARR charts issued for care homes that did not match the details of the prescriptions such as the wrong medicines and the wrong dosages. Staff were reminded to always carefully cross check the details of the prescriptions, MARR charts and patient medication records all matched.

Records of errors and near misses were reviewed during monthly patient safety reviews for each of the different dispensing areas. Learning points were identified and discussed with the pharmacy team. The action points recorded in a March 2019 review included to ensure all split packs were marked. There were prompts highlighted on medicine shelves to remind staff about 'look alike, sound alike' medicines.

Dispensing errors were recorded and reported to Head Office via an online reporting system. Any dispensing errors were reviewed at the time of the occurrence and then a review form was completed monthly by the pharmacist to identify any trends and these would be discussed with members of staff.

An error had been reported where a patient prescribed fluoxetine had been discharged from hospital and the dosage had been reduced from twice daily to once daily. The pharmacy checked this with the surgery and the information at the time was confirmed by a receptionist as twice daily, but the information had not been checked with the prescriber. The pharmacy then appeared to have made an error and dispensed the medicine with the previous dose of twice daily but upon investigation, the surgery had in fact made the error. As a result, staff were reminded to ensure any changes were double checked with the prescriber as this information had been confirmed by the receptionist, prior to supplying it to the patient.

Weekly clinical governance checks were completed by the Responsible pharmacist and recorded in the diary. This included checking the Responsible pharmacist notice was displayed, carrying out weekly CD balance checks and confirming that the fridge temperatures were recorded daily.

A responsible pharmacist (RP) notice was prominently displayed. When questioned, a dispenser understood that staff could not sell P medicines or hand out dispensed medication in the absence of the pharmacist. Pharmacy staff wore name badges including their job titles. A complaints procedure was in place. There was a current professional indemnity insurance certificate available.

The CD registers were in order and running balances were recorded and audited weekly. There was a patient CD returns register in use. Records of private prescriptions, emergency supplies, RP and specials procurement had all the necessary details documented.

Confidential waste was stored separately to general waste and was collected in blue bags which were available in the dispensary, care home room and multi-compartment compliance aids room. These were collected regularly and sent to Head Office for disposal. The patient medication records (PMR) were protected with username and password access. Confidential information such as prescription repeats were stored securely. All staff had access to their own Smart cards which were stored on their person and stored securely overnight. All staff had completed e-Learning modules on information governance and this was repeated annually. The pharmacists and technicians had completed CPPE training on safeguarding. Staff said that they completed annual Boots e-Learning modules on safeguarding. The details of local safeguarding contacts were available in all dispensaries. There was a chaperone policy in place.

Principle 2 - Staffing ✔ Good practice

Summary findings

There are enough staff to provide services safely and effectively and they are properly trained for the jobs they do. They participate in continuous learning to help keep their knowledge up to date.

Inspector's evidence

At the time of inspection there were four Pharmacy Technicians, two of whom were employed as ACTs, 16 dispensers and two relief pharmacists. They were seen working in different areas of the business in the main dispensary downstairs, in the multi-compartment compliance aids room and in the care homes room.

Another pharmacist employed as a store manager usually worked in branch but had a day off at the time of the inspection. Staff were trained in different areas of the business so that they could cover holidays and absences e.g. care homes room and multi-compartment compliance aids room. The pharmacy was busy in all departments but the staff were able to manage their workload.

There would usually be two pharmacists working; one of whom would check walk-in prescriptions and collection prescriptions in the main dispensary and the other helped with care homes and to cover lunch breaks in the main dispensary. The store manager was given additional cover so that he was able to carry out his management role. Delivery drivers operated from a hub to provide a prescription collection and delivery service.

Staff would communicate any important messages by 'huddles' or informal meetings. An ACT for the care homes said that they had meetings on an ad hoc basis where they were able to speak informally about various issues such as near misses and progress of work for the care homes. Each dispensary had a red tray where important messages and queries had to be followed up and details of follow-up notes were recorded on the audit sheets so that there was continuity of workflow.

Head office sent regular bulletins to update staff on professional matters such as changes to practice or new legislation such as the changes to the classification of pregabalin and gabapentin.

Staff said there was a whistleblowing policy in place and a designated confidential number where concerns could be reported, in addition to store management or to the area manager.

Staff explained that, when selling medicines, they would provide information to help make sure they would be used safely. If they were asked for a recommendation, they would ask questions based on WWHAM. Staff were aware of medicines liable for misuse, such as co-codamol, and said if these medicines were requested they would refer to the pharmacist, if unsure.

All members of staff completed mandatory e-Learning based training which was monitored by head office. The pharmacy manager and assistant manager was responsible for ensuring the training was up to date. Staff were also provided with '30-minute tutor' training booklets which they were encouraged to complete but which were not mandatory. All staff were up-to-date with training. Appraisals were conducted quarterly. Individual's progress and improvements that could be made to the business were discussed.

There was a member of staff who telephoned each care home to check and review that they were happy with the service provided by the pharmacy. Staff were set targets as a team for MURs and pharmacy services and to ensure that medication for care homes was sent out on a set day. They said they did not feel pressured to achieve these targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy environment is safe and appropriate for the services provided.

Inspector's evidence

The premises was tidy and clean. Cleaning rotas were in place for the different areas of the pharmacy business e.g. mult-compartment compliance aids room, care homes room and dispensary downstairs which staff would sign to say that tasks such as cleaning the shelves, floors and work benches had been completed.

The main pharmacy area was located on the ground floor. There were two further dispensing areas in use for dispensing medicines in multi-compartment compliance aids for care homes and for community patients; these areas were located on the first floor and were not accessible to the public.

There was a dispensary sink for each of the care homes room and multi-compartment compliance aids room and main dispensary. There were separate sinks in the rest rooms for staff and a separate area for staff rest breaks.

There was adequate lighting. There was a seating area for patients waiting for prescriptions, next to the dispensary. The ambient temperature was not monitored but was appropriate for the working environment.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of services and takes steps to make them easy to access. The pharmacy manages its services well so that people receive their medicines safely and get the right healthcare advice. It obtains its medicines from reputable suppliers and stores them appropriately. And the team makes some additional checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had step-free access from the pavement and an automatic front door and additional doors. A hearing loop was available. Leaflets and posters were on display covering a wide range of health topics. A text messaging service was available where patients could be notified if their prescription was ready for collection from the pharmacy.

A delivery service was offered and signatures were obtained when medicines were delivered. Copies of delivery sheets were retained at the pharmacy and details of whether there was a CD item or fridge item to deliver was indicated by a CD or fridge sticker along with a laminated card. Each patient received a phone call to arrange for their delivery at a time which was convenient to them. Any failed deliveries were returned to store or the hub.

Staff were aware of the need to signpost people requesting services not offered from the pharmacy. A dispenser was able to identify that patients requesting needle exchange were signposted to the neighbouring Boots pharmacy.

A dispensing audit trail was maintained by the practice of staff signing their initials on the dispensed and checked by boxes on dispensing labels. Quadrant stamps were marked on all prescriptions and initialled to show who was responsible for each stage of the dispensing procedure. An ACT explained that she was not allowed to carry out a final accuracy check until a prescription had been clinically checked by the pharmacist and the dispenser had completed all of the dispensing process.

Dispensed medicines awaiting collection were stored in a retrieval system and prescription forms were filed separately so that they could be retrieved when the medicines were handed out. The staff were seen retrieving a prescription and confirming the patient's details before handing out.

Pharmacist information forms (PIFs) were used during the dispensing procedure to record any information that might need to be highlighted. The forms were then retained with prescription forms until the medicines were handed out to alert the pharmacist to important information about the prescription, such as whether it was a new medicine or a change of dose. This supported the clinical assessment of the prescription and any counselling the patient needed.

Prescriptions containing high risk medicines; such as anticoagulants, methotrexate or CDs had a coloured laminated card attached to alert the staff member handing out the prescription that extra counselling or checks were required. CDs also had stickers attached indicating the last date on which the prescriptions could be collected, so staff would be aware of any prescriptions that may be out of date.

The pharmacy received faxed information from the care homes providing INR readings for patients prescribed warfarin, so that they could check the doses were appropriate. The INR results were recorded and filed in the patient's records.

Staff explained that they were aware of the Falsified Medicines Directive (FMD) and had been given some information from head office. But they had not been fully trained and the necessary equipment had not yet been installed. So, the pharmacy was not yet able to comply with the requirements of the legislation.

When questioned, staff were aware that valproate prescriptions should be highlighted during the dispensing process. An audit had been carried out to identify any valproate patients who might be at risk of pregnancy. Any prescriptions for patients meeting the criteria of being on a pregnancy prevention programme were highlighted on the attached PIFs so that the patient could be counselled by the pharmacist. Educational material was available and staff knew this needed to be provided every time valproate was supplied to a person who may become pregnant.

Dispensing trays were used to avoid mixing up prescriptions during the dispensing. Any prescriptions awaiting stock or only part dispensed were stored in the trays and kept to one side.

Medicines were dispensed in multi-compartment compliance aids for residents of several care homes and also for a number of patients in their own homes. Community multi-compartment compliance aids were assembled in a separate room to the care home medicines because of the large volume dispensed.
Patient information leaflets were provided with the compliance aids at the beginning of each monthly cycle. Descriptions were included on the medication labels to enable individual medicines to be identified. Dispensed by and checked by boxes were signed on the medication labels to provide an audit trail.

Any medication changes for patients using compliance aids were documented on the patient medication records and individual filed records which were kept separately for each patient. A progress log was kept for each week so staff were able to track when prescriptions had been ordered, when prescriptions had been clinically checked and labelled and when prescriptions had been finally checked.

As there were a lot of complianced aids dispensed, the assembly of the compliance aids was split into four weeks and compliance aids were colour coded to distinguish between the four weeks.

MARR charts were issued with multi-compartment compliance aids to monitor and record whether medicines had been taken. They were always supplied to the care homes and were supplied to community patients if requested.

Most care homes had service level agreements with the pharmacy to supply medication in conventional containers. Medication for some of the care homes was assembled at a hub pharmacy (CSSP) in Nottingham which produced pre-packs of widely used medicines such as atenolol and amitriptyline. Stock ordered from the CSSP was usually delivered on the next working day.

A care home progress log was kept for each week, so staff were able to find out when prescriptions had been ordered, when prescriptions had been clinically checked and labelled and when prescriptions had been finally checked. Any important messages were documented on the patient medication records and in the individual care home diaries. Interim prescriptions which needed to be provided to the care homes were usually faxed to the pharmacy. The pharmacist checked that they were legally and clinically appropriate before supplying them to the care homes. The original prescriptions were obtained by the

pharmacy within 24 hours.

Clozapine was dispensed for around 35 patients. Some of these were supplied in multi-compartment compliance aids. Prescriptions for clozapine were issued by a psychiatric unit, but other medicines for these patients had to be ordered from the GP. A brand of clozapine called Clozaril was provided to patients that had been stabilised on a particular dose and the blood results were accessible by a secure blood monitoring service called Clozaril Patient Monitoring Service (CPMS).

A file was kept in which each Clozaril patient had their own individual log sheets with records of prescriptions and any changes, the last blood test results and when next blood tests were due. The pharmacy staff liaised closely with the psychiatric outreach team who cared for these patients in the community and also had access to the Clozaril Patient Monitoring Service website. The pharmacy could only provide Clozaril to patients who received a green or amber blood result. If there were no blood results obtainable on the CPMS system, the staff would receive an email notification advising them of this. This allowed them to monitor patients' blood test results. All relevant staff had individual identification numbers to access the website and would liaise with nurses if patients had not had blood tests done. A clozapine communications diary was used to record any queries or other communication. Staff said that Clozaril could not be dispensed to patients who did not have blood tests done and the pharmacy staff would liaise with the outreach nurses to resolve the matter. Clozapine was ordered directly from the manufacturer and stock was kept locked away in drawers to avoid error.

Compliance aids for clozapine patients were assembled in a specific area which was segregated from the dispensing of routine compliance aids. Separate delivery notes were attached to each patient's compliance aidss and clozapine deliveries were regarded in the same way as CD deliveries where patients were expected to sign for their medication. This procedure had been put into place because of the nature of medication being supplied to vulnerable patients.

Medicines were obtained from licensed wholesalers. Date checking matrices were used to record and manage regular expiry date checks of stock in all three dispensaries. Short dated medication was marked with stickers. Stock was generally stored in alphabetical order according to generic name and internal and external liquids were kept separately. Open dates were indicated on internal liquids along with expiry dates. Stock was stored separately in an A-Z room for the multi-compartment compliance aids and care homes compliance aids.

Some stock packs were found to contain mixed batches and expiry dates. These included: boxes of Eliqus 2.5mg tablets, cinnarizine 15mg tablets, Xatral XL 10mg tablets, furosemide 20mg tablets and co-codamol 30/500mg tablets in the A-Z room; boxes of nitrofurantoin 50mg capsules, trimethoprim 100mg tablets, flucloxacillin 500mg capsules and cefalexin 250mg capsules in the care home room. This does not meet statutory labelling requirements and may increase the risk of error.

There were six fridges in use to store medicines; all of which had thermometers. Temperatures were monitored daily and recorded and were in the required range. Fridge medicines awaiting collection were kept in clear bags and the contents were checked with the patient at the point of handout. The medicines in the fridges were stored in an organised manner.

CDs were appropriately stored. The pharmacy dealt with a large volume of medication waste, which was disposed of in designated bins for storing aste medicines that were collected approximately every four to six weeks. Drug alerts were printed out from emails sent by Head Office as well as alerts from the intranet and records were kept showing they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs for the services that are provided.

Inspector's evidence

There were current reference books in use such as a BNF, Children's BNF and Drug Tariff in all areas of the pharmacy. A range of clean, crown stamped measures were available in all three dispensaries. Separate measures were available for preparation of antibiotics. Counting triangles were available. There was a separate, marked triangle used for cytotoxic medicines.

There was heat sealing equipment available in the care home room which was serviced regularly. All electrical equipment was in good working order.

Internet access was available and the relief pharmacists said they accessed the electronic medicines compendium to obtain patient information leaflets. There was a username and password for the patient medication records access on the computer terminals. The computer screens were turned away from the public view. The dispensary afforded good privacy for the dispensing operation and any associated conversations or telephone calls.

Patient medication records were stored electronically and access was password protected.

Cordless telephones were in use in all areas of the pharmacy to prevent patients or members of the public using the pharmacy overhearing.

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.