General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 78 High Street, BROMSGROVE, Worcestershire, B61 8EX

Pharmacy reference: 1038815

Type of pharmacy: Community

Date of inspection: 01/04/2019

Pharmacy context

The pharmacy is a large community pharmacy in the main shopping area of a town. The pharmacy dispenses NHS prescriptions and sells a large range of over-the-counter medicines and other products. It supplies medicines in multi-compartment devices for several care homes as well as for people in their own 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	1.4	Good practice	The team members encourage people to give feedback in several ways and they use this to improve their services.
2. Staff	Standards met	2.4	Good practice	The staff are encouraged to keep their skills up-to-date and those team members, who are training, are well supported.
		2.5	Good practice	The pharmacy team are well supported. They are comfortable about providing feedback to their manager and this is acted on.
3. Premises	Standards met	3.2	Good practice	There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk.
4. Services, including medicines management	Standards met	4.1	Good practice	People with a range of needs can access the services offered by the pharmacy.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identify and manage risks satisfactorily. But, they could learn more from mistakes to prevent them from happening again. The team members encourage people to give feedback in several ways and they use this to improve their services. The pharmacy is appropriately insured to protect people if things go wrong. The team keep the up-to-date records that they must keep by law and they know how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing errors and incidents were recorded, reviewed and appropriately managed. Two weeks before the visit there had been a paediatric labelling error. A third check, as required by the company's Standard Operating Procedures (SOPs), for paediatric medicines, had not been done. Because of this, the staff had all re-visited the SOPs for these.

Near misses were recorded but the log used had insufficient space to record enough information for any useful analysis, such as a recent labelling error. No learning points or actions to reduce the likelihood of a recurrence were recorded. The company had just introduced a new near miss log which did have space for these to be recorded. The pharmacist said that, in future, she would try to make sure that the staff recorded enough information to allow learning points and actions to be identified. General trends were identified. In March 2019, there had been several quantity errors during the lunch period. Because of this, the hand-over procedures had been reviewed but no specific actions, such as initialling the quantity to demonstrate that this had been thoroughly checked, had been put in place.

The staff reported that they were supported to learn from any mistakes. Select with care labels were seen on several shelf-edges, such as with amlodipine and amitriptyline. The risk of picking errors with 'look alike, sound alike' drugs was identified such as propranolol and prednisolone. The Superintendent's Office had recently sent a laminated sheet containing six drugs, quinine, quetiapine, atenolol, allopurinol, amlodipine and amitriptyline. These were displayed on the computer monitors with instructions that these should be highlighted on the 'Pharmacist information Forms' (PIFs) that were attached to all prescriptions. The Superintendent's Office also sent monthly professional standards bulletins which all the staff signed to demonstrate that they had been read.

The main dispensary was limited in size, but the space was well utilised. There was one work station on the front bench which was well screened. The staff reported that only acute prescriptions with one to two items were dispensed here because of the possible accidental disclosure of confidential information. The rear area of the dispensary was used for the assembly and checking of large prescriptions and repeat prescriptions. There were clear assembly and checking areas and an area for prescriptions with any queries. Shelves above the checking area were used for items that were waiting to be checked or those with items owed to patients to keep the small checking area as clear as possible. Upstairs, there was a separate spacious room which was used for all the monitored dosage system service (MDS) prescriptions. There was also a separate stock room for the MDS services.

Coloured cards were used which highlighted, amongst others, patients who were waiting, those calling back and prescriptions containing fridge items, paediatric doses, warfarin, methotrexate and controlled drugs. All assembled prescriptions examined had a completed PIF where any relevant information was

recorded. High-risk drugs and high-risk patients were identified and appropriately counselled.

There was a clear audit trail of the dispensing process and all the ‘dispensed by' and 'checked by’ boxes on the labels examined had been initialled. In addition, all prescriptions contained a four-way stamp which included the initials of who had done the clinical check, the dispensing, the accuracy check and the hand-out. Regular audits were undertaken by the area manager and clinical governance pharmacists. Risk assessments were performed such as one in September 2018 prior to the seasonal ‘flu vaccination service being offered.

Up-to-date, signed and relevant Standard Operating Procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the Superintendent Pharmacist. The roles and responsibilities were clearly set out in the SOPs and the staff were clear about their roles. A care card for medicines sales, specific to the store, was prominently displayed close to the medicine counter. This was signed and dated and included local additions, such as, codeine-containing products. A NVQ2 qualified dispenser reported that she would refer all requests for customers on prescribed medicines to the pharmacist. She also asked customers if they were taking any herbal medicines. Care cards were attached to the storage positions of items that should be referred to the pharmacist, such as, ‘prescription only’ (POM) to ‘pharmacy only’ switches, such as Viagra Connect and Ella One.

The staff were clear about the complaints procedure and reported that feedback on all concerns was actively encouraged. The company operated a random feedback procedure and some till receipts gave instructions on how to provide feedback and raise concerns. All feedback was collated by the company’s Head Office and passed onto the store if appropriate. In addition, there were cards close to the till giving customers instructions on how to provide feedback. The store manager looked at this feedback regularly.

An annual pharmacy specific customer satisfaction survey was also done. In the 2018 survey, 94% of customers who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about having medicines in stock. Because of this, the pharmacy checked the stock both downstairs and upstairs before issuing an ‘owing note’. The staff also made sure that they had appropriate stock levels of their top 50 items. A text service was offered whereby a message was sent to patients letting them know that their prescriptions or items that were owed to them were ready to collect.

Current public liability and indemnity insurance was in place. The Responsible Pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order. The specials records were however not filed in an organised manner. The store manager said that she would address this.

There was an information governance procedure and the computers, which were not visible to the customers, were password protected. Confidential information was stored securely. There was no clear queuing system for customers and this increased the likelihood of the accidental disclosure of confidential information. Sensitive telephone calls were taken in the consultation room or out of earshot. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff had a good understanding of safeguarding issues and had completed the company’s e-learning module on the safeguarding of both children and vulnerable adults. The pharmacist and technicians had also completed the Centre for Pharmacy Postgraduate Education (CPPE). The procedures to follow in

the event of a safeguarding concerns were displayed as were the local telephone numbers to escalate any concerns relating to both children and adults. All the staff had completed ‘Dementia Friends’ training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage their workload safely. But, sometimes they fall behind with their work schedule. The staff are encouraged to keep their skills up-to-date and they generally do this in work time. The team members who are training are well supported. The pharmacy team are comfortable about providing feedback to their manager and this is acted on.

Inspector's evidence

The pharmacy was in the main shopping area in the centre of Bromsgrove. They dispensed approximately 11000 prescription items each month with the majority of these being repeats. 50 domiciliary patients and 300 care home patients (nursing and residential) received their medicines in monitored dosage systems (MDS). Few private prescriptions were dispensed.

The current staffing profile was 1.5 full-time equivalents (FTE) pharmacists (there was a vacancy for a part-time (PT) pharmacist), two PT accuracy checking technicians (ACTs), four PT NVQ2 trained dispensers and three PT NVQ2 trainee dispensers. In addition, the store manager was a trained dispenser. The assistant managers, one a trained dispenser and one a trainee, could also help, if necessary. There were no dedicated counter staff.

The part-time staff were flexible and generally covered any unplanned absences. If necessary, the staff worked overtime or relief dispensing help or additional pharmacist cover was obtained. Planned leave was booked well in advance and these hours were generally back-filled.

On the day of the visit, there were three pharmacists on duty, one, newly appointed, was in her induction period. An ACT reported that she sometimes had to work as a dispenser. A pharmacist said that she was checking the prescriptions for a home that had to be delivered the next day. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this.

The staff were encouraged with learning and development and completed e-learning and 30-minute tutors, such as recently on fungal foot infections. The staff reported that they usually spent at least 30 minutes each month of protected time learning but some staff did this learning at home. There was no dedicated training rota. The staff enrolled on accredited courses, such as the NVQ2 dispensing assistant course, were allocated a further hour each week for learning. All the dispensary staff reported that they were supported to learn from errors. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. The staff said that they were supported by their managers. A trained dispenser had recently asked if he could reduce his working hours and this had been granted. There were daily staff ‘huddles’ and monthly dispensary meetings. All the staff at the store met every quarter. All the staff were aware of the company’s whistle-blowing policy. A reported that she was set overall targets, such as 400 annual medicine use reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional. It is tidy and organised. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. There is good seating for people who are waiting and an additional area for people to talk privately.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. There was a large separate MDS room and a separate room for the stock for these prescriptions. The premises were clean and well maintained.

The consultation room was spacious and well signposted. It contained a computer, a sink and three chairs. Conversations in the consultation room could not be overheard. There was a further consultation area which was well-screened and had a computer. Good seating was provided for customers who were waiting. The computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. There was good lighting throughout. Healthcare medicines were located immediately adjacent to the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the services offered by the pharmacy.The pharmacy team make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried or think that they may not be taking or using their medicines as prescribed by their doctors. But, the team could make sure that they are working sufficiently in advance so that the medicines for care homes are sent on time without undue pressure to achieve this. The pharmacy gets its medicines from appropriate resources. The medicines are stored and disposed of safely. The pharmacy team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with an automatic opening front door. The store had a translation application on their iPad for non-English speakers. The pharmacy could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were medicine use reviews (MURs), new medicine service (NMS), supervised consumption of methadone and buprenorphine and seasonal ‘flu vaccinations. The latter was also provided under a private agreement as were malaria prophylaxis, meningitis B vaccine and chicken pox vaccine.

The regular pharmacists had completed suitable training for the provision of seasonal ‘flu vaccinations and other vaccination services including face to face training on injection technique, needle stick injuries and anaphylaxis. They had also completed the Gateway training on the prophylaxis of malaria.

A large proportion of the business at the pharmacy was the assembly of medicines into monitored dosage systems (MDS). 50 domiciliary patients and 300 care home (nursing and residential) received their medication in MDS packs. These were assembled in a separate spacious room upstairs. The room had a domiciliary area, 2 care home work stations, an interim area and an administrative area.

The domiciliary dosettes were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There was a clear progress log of the entire process. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. The company had introduced new procedures for the domiciliary trays. This required that, following any changes, a new sheet was to be completed. The old sheets were kept, but potentially the poly-pockets could become overly full. In addition, there was no clear concise chronological audit trail of changes or issues. This denied the checking pharmacist easy reference to the past clinical history or any other issues with the patient. The surgeries for these patients did not always let the pharmacy staff know if patients, who were prescribed high-risk medicines, such as methotrexate or warfarin, were receiving the appropriate blood tests.

Services for the care homes were well organised and there was a dedicated care home manager. However, the staff reported that they used to use dedicated communication diaries for each home where any issues were recorded. This system made it easy for them to refer to any past issues. The

company had changed these procedures. Now a separate sheet was filled in. These had to be filed, which was time consuming. In addition, it was extremely difficult to locate any previous issues. The homes ordered the prescriptions on behalf of their patients. The prescriptions were sent to the homes for checking. Query sheets were sent to all the homes but answers were not always received in a timely manner. These sheets included questions about appropriate blood tests for patients prescribed high-risk medicines. The pharmacy employed two part-time ACTs. The one seen on the day of the visit said that she frequently had to dispense medicines and so was unable to do the final accuracy check. As reported under principle 2, a pharmacist working in the MDS room was checking the medicines for a home that had to be delivered the next day. This increased the risk of errors. Several queries about these prescriptions were seen not yet to have been resolved. The staff said that sometimes they got the prescriptions for the homes late which put them under pressure. Any faxed interims prescriptions were reconciled the same or the next day.

The homes were visited by a pharmacist once or twice a year, according to the size, to check on medicines management and other issues. The staff at the homes followed the Boots training procedures which included some face-to-face training. The pharmacy staff gave any required advice over the telephone if necessary.

There was a good audit trail for all items dispensed by the pharmacy, but any items ordered on behalf of patients using Webscript only documented the number of items ordered and not the exact details. The pharmacists routinely counselled 'walk-in' patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. Most acute ‘walk-in’ patients were counselled. The pharmacist also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. The staff were aware of the new sodium valproate guidelines. They had two female patients of child-bearing age who were sent the appropriate advice with each prescription.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist on the PIFs. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Suitable patients were encouraged to use the company’s managed repeat prescription service so that all regular prescribed items ran in line to reduce wastage, to optimise the use of medicines and to identify any non-adherence issues. Patients were asked to check when they collected their medicines if they still needed everything that they had ordered the previous month. Any patients giving rise to concerns were referred to the pharmacist for counselling.

The pharmacist reported that she had done a MUR with a patient recently who was complaining of blurred vision and headaches. She suggested to the person that she went to nearby optician. It subsequently transpired that the patient had a tumour. The patient came back into the pharmacy to thank the pharmacist for her intervention.

Medicines and medical devices were obtained from Alliance Healthcare, AAH and Boots Head Office. Specials were obtained from Alliance Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. There were a few patient-returned CDs but no out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Other stock was stored tidily on the shelves. Date checking procedures were in place with signatures recording who had undertaken the task. Doop bins were available for waste and used and there was a cytotoxic bin and list of substances that should be treated as hazardous for waste purposes. The pharmacy staff were aware of the Falsified Medicines Directive but the pharmacy had no scanners to check for falsified medicines.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 4 February 2019 about amoxicillin 500mg capsules. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 500ml). There were two tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2018/2019 Children's BNF. There was access to the internet and to Medicines Complete.

The fridges were in good working order and maximum/minimum temperatures were recorded daily. Doop bins were available and used and there was adequate storage for all other medicines. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential was information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.