General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 3 Wimbourne Place, DAVENTRY, Northamptonshire, NN11 0XY

Pharmacy reference: 1081493

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

This community pharmacy is situated in a small shopping precinct next to a doctor's surgery. Most of its activity is dispensing NHS prescriptions and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance aids to people who live in their own homes. Other services which the pharmacy provides include prescription deliveries to people's homes, Medicines Use Reviews (MUR), the New Medicine Service checks (NMS), flu vaccinations under both private and NHS patient group directions (PGDs), and gluten free products.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Good practice	1.1	Good practice	Members of the pharmacy team are clear about their roles and responsibilities. They work to professional standards and identify and manage risks well.
		1.2	Good practice	The pharmacy has good processes for learning from mistakes and uses these to improve the safety and quality of the services it provides.
2. Staff	Good practice	2.1	Good practice	The team members manage the pharmacy's workload well. It has contingency arrangements in place to cover staff absence.
		2.3	Good practice	The pharmacy empowers its team members to act in the best interests of the people who use its services.
		2.4	Good practice	The pharmacy has a work culture of openness, honesty and training.
		2.5	Good practice	The pharmacy actively seeks its team's views on how to improve services and implements good suggestions.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.2	Good practice	People receive the advice and support they need to help them use their medicines appropriately. The pharmacy proactively identifies people taking high-risk medicines to ensure they get the advice they need to take their medicines safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

Members of the pharmacy team are clear about their roles and responsibilities. They work to professional standards and identify and manage risks well. The pharmacy has good processes for learning from mistakes and uses these to improve the safety and quality of the services it provides. The pharmacy adequately manages people's personal information and knows how to protect vulnerable people.

Inspector's evidence

The responsible pharmacist (RP) notice showing the pharmacist in charge of the pharmacy was clearly displayed. As part of the dispensing of a prescription a pharmacist's information form, referred to as a PIF was completed. Staff explained that the PIF was used to highlight key risks to the pharmacist such as new medicines, change of dose or strength. Prescriptions checked had a PIF attached and had a range of information recorded to allow the team to give appropriate advice to people collecting medicines.

The pharmacy had an up-to-date set of standard operating procedures (SOPs), signed by staff, which reflected how the pharmacy operated. Staff were observed to follow the SOPs with an audit trail created to show who had dispensed the medicine; the PIF was completed and controlled drugs (CDs) running balances were checked weekly. Staff understood their roles and responsibilities.
The pharmacy team were aware of the principle behind the look alike sound alike (LASA) process. There were laminates with the computers which listed the names of the common medicines. Staff could explain the process which included writing the name of the medicine on the PIF. PIFs checked had the information recorded. In addition to the medicines highlighted by head office the pharmacy was able to highlight its own LASA medicines. As a result of an error the pharmacy had added sildenafil to its list of LASAs the previous month. This had seen a reduction in the number of near misses for that medicine.

A weekly clinical governance check was carried out. This ensured the pharmacy was reviewing risks such as whether SOPs were being followed; legal records were up to date; medicines were stored appropriately, and incidents were reviewed.

The pharmacy had a number of prompt cards which were placed with dispensed prescriptions. Cards said if there was a CD or fridge line or to refer a person collecting a prescription to the pharmacist for counselling. In addition, there were cards for higher-risk medicines such as lithium, methotrexate or warfarin, with questions the person handing out the medicine should ask on the back. The dispensed prescriptions checked had a prompt card in the wallet with the prescription.

The counter assistant had an understanding of how to sell a medicine safely. She didn't explain the two protocols that Boots use depending on whether a medicine is asked for by name or by symptom. She had some product knowledge. She knew that CDs had a 28 day validity but was not sure of all the CDs that were not kept in the CD cupboard but said that they were all highlighted by the dispensary team. She was aware that gabapentin and pregabalin were now valid for 28 days. The dispenser explained that for CDs not in the cupboard he wrote CD and the supply by date on the PIF. PIFs seen for zopiclone and pregabalin had the information recorded.

The pharmacy had a colour-coded system for all prescriptions waiting collection. If people hadn't

collected after four weeks the staff texted them and then took the medicine off the shelf and returned the prescription back to the NHS spine.

The pharmacy kept dispensed CDs and insulin in clear bags to allow the medicines to be easily checked before they were supplied. Dispensed CDs in the CD cupboard had a CD sticker with the date that they should be supplied by.

The pharmacy kept records of near misses and errors or other incidents. Near misses were discussed at the time they were found with the member of staff responsible. The pharmacist or the dispenser then made a record in the near miss log. Most of the near miss log had a comment that gave an indication about the reason for the error. At the end of the month a patient safety review was carried out by the pharmacist with the safety patient champion. The latest review was on the dispensary wall to remind staff of the actions for that month. A member of staff was able to explain the three actions and the reasons behind them. It had been signed by all staff.

The pharmacy safety champion could clearly explain her role. She explained that she carried out the monthly review of the near misses with the pharmacist. She made sure staff were up to date with any changes and new SOPs. She made sure that staff had read the Professional Standard, read the latest learning and completed the quiz.

The pharmacy received a letter from the superintendent highlighting changes in procedures and learning points across the stores. The latest letter had been signed by staff to show they had read it.

There was a complaints procedure in place. The customer complaints number was on the back of the till receipt. There was a pharmacy leaflet available which gave a range of external organisations that people could contact.

The latest patient satisfaction survey from March 2019 was on the website NHS UK and on display in the consultation room. 93% of patients rated the pharmacy as excellent or very good. The biggest concern was over having somewhere for a private conversation. The pharmacist said that people were not always aware that there was a consultation room and that additional signage might be required. The pharmacist said that if the patient looked nervous or it was a sensitive issue she would offer the consultation room.

Public liability and professional indemnity insurance were in place. Records to support the safe and effective delivery of pharmacy services were generally maintained in line with requirements. These included the RP record book and the controlled drug register. The pharmacy recorded private prescriptions electronically. On the prescription checked, the team had recorded the wrong prescriber. This did not meet legal requirements and meant it would be harder to check details if there was a query about the prescription.

CD running balances were checked on a weekly basis. A random check of the recorded running balance of a CD reconciled with the actual stock in the CD cabinet. Out of date CDs required destruction. Patient returned CDs were recorded in the patient returned register. All had been destroyed.

Computer terminals were positioned so that they couldn’t be seen by people in the retail area. Access to the electronic patient medication record (PMR) was password protected. People's confidential information was stored securely; confidential waste was bagged and sent away for secure destruction.

The pharmacy team were aware of the safeguarding procedure; the pharmacist had completed the CPPE training. Local contact details were available if the pharmacy needed to raise any safeguarding

concerns.

Principle 2 - Staffing ✔ Good practice

Summary findings

The team members manage the pharmacy's workload well. It has contingency arrangements in place to cover staff absence. The pharmacy empowers its team members to act in the best interests of the people who use its services. The pharmacy actively seeks its team's views on how to improve services and implements good suggestions. The pharmacy has a work culture of openness, honesty and training. People who work in the pharmacy do ongoing training to help keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. The pharmacy team was able to manage the workload to provide pharmacy services safely. During inspection the pharmacy had one pharmacist; one qualified counter assistant and two qualified dispensing assistants. One dispenser was a relief dispenser who was covering some long-term illness. The pharmacist also had a second pharmacist once a week. The pharmacy team engaged with the inspection process and worked well together.

Staff said that they had appraisals every six months and had an input into the process. Staff said that the manager was easy to speak to. One of the dispensers had started the pharmacy technician course after requesting it at her appraisal. Staff were involved in improving the service. They could give examples of changes made such as changes in rotating tasks in the dispensary across the team. There was a range of training for all staff on the e-Learning site; and the 30 minute tutors which was a monthly paper-based training. Staff could explain the last training that had been completed.

The dispenser said that she studied the pharmacy technician course at home but that she was able to discuss the course and could ask any questions with the pharmacist at work. She said that other training was completed during work time. The pharmacist said that the targets set motivated her and the team and didn't compromise customer service or her professional integrity.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. It protects people’s confidentiality. The premises are secure from unauthorised access when open and when closed.

Inspector's evidence

The dispensary was an adequate size for the number of prescriptions dispensed. There was an adequate dispensing bench available for the assembly of medicines. The dispensary was clean and tidy; there was a sink with hot and cold water. The pharmacy had air conditioning to provide an appropriate temperature for the storage of medicines; lighting was sufficient.

A reasonable size consultation room was available to ensure that people could have confidential conversations with pharmacy staff. Computer screens were set back from and faced away from the counter. Access to electronic patient records (PMR) was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Good practice

Summary findings

The pharmacy provides its services safely and effectively. People receive the advice and support they need to help them use their medicines appropriately. It proactively identifies people taking high-risk medicines to ensure they get the advice they need to take their medicines safely. The pharmacy stores medicines safely. The pharmacy responds well to drug alerts or product recalls to make sure that people only get medicines which are safe.

Inspector's evidence

The pharmacy was in a small shopping centre next to the medical centre. There was flat access and an automatic door which provided easy access for those in a wheelchair or with a physical disability. Although it was double doors only one door opened automatically; the pharmacist said the single door was wide enough for a pushchair or wheelchair. There were signs advertising the opening hours and services provided. The route to the dispensary was clear. The pharmacy had a hearing loop.

Work was prioritised based on whether the prescription was for a person who was waiting or coming back or was for a delivery. The pharmacy used a dispensing audit trail which showed who had been involved in dispensing the prescription. The pharmacy used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of medicines.

The pharmacist said that she gave advice to people on a range of matters including change in doses or new medicines. She focused on children and people with diabetes. She gave advice to people buying over-the-counter medicines. She said that she knew most of the people using the pharmacy and knew the medicines they were taking. She said that staff routinely asked the questions on the prompt cards for people on higher risk medicines such as warfarin, methotrexate and lithium. The warfarin script checked had the INR recorded on the PMR. The pharmacist understood the risks with sodium valproate during pregnancy and the advice that should be given. She had carried out an audit and there were two patients in the at-risk group taking sodium valproate. The pharmacist said that she had spoken to them and made records of the conversations on their PMR records . She regularly gave out the alert card.

The pharmacist understood the signposting process and used local knowledge to direct patients who needed support from other healthcare providers. The pharmacy had two fridges. Records showed that fridge lines were stored correctly between 2 and 8 degrees Celsius. Current temperatures were within range. The fridges were well managed.

Medicines were stored on shelves tidily and in original containers. Date checking was carried out on a three month rotation; short-dated stickers were used. Out-of-date medicines were put in yellow waste bins. Bottles had an opening date recorded. The dispenser said that if there was no specific expiry date she would use an open bottle for up to six months and then discard it.

Each person who received their medicines in a multi-compartment compliance aid had an individual record which listed their medicines and when they should be taken. Any changes in or missing medicines were checked with the surgery before being dispensed. The chart was changed each time there was a change in medicine which made them neat and easy to follow. Original packs were kept in the basket to allow the pharmacist to easily check. On the compliance aid checked the medicine labels

recorded the shape and colour of the medicine to allow easy identification. Patient information leaflets (PILs) were provided to people each month.

CDs were stored safely. Access to the CD cabinet was managed appropriately. The pharmacy delivered medicines to people. The person who received the medicine signed for the medicine. The pharmacy only had records for CD deliveries but records for other medicines would be available from the hub if required.

Only recognised wholesalers were used for the supply of medicines.
The pharmacy team were aware of the procedure for drug alerts. A record was created and signed to provide a complete audit trail. The pharmacy had not yet implemented Falsified Medicines Directive requirements and wasn't aware of when it would be implemented in the store.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services it offers. It adequately maintains the equipment and facilities that it uses.

Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. The pharmacy also had tablet and capsule counters. The pharmacy had a range of up-to-date reference sources.
Electrical appliance testing was next due in October 2019. Confidential patient information was stored securely. Confidential waste paper was collected in a confidential waste bag and taken away for destruction.

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.