General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit E, Eastgate Centre, Eastgate Road, BRISTOL, BS5 6XX

Pharmacy reference: 1089407

Type of pharmacy: Community

Date of inspection: 11/04/2019

Pharmacy context

The pharmacy is a large community pharmacy on a retail park close to the centre of Bristol. It sells over-the-counter medicines and several non-healthcare related items. The pharmacy is open every day and dispenses NHS prescriptions. It also provides medicines in multi-compartment devices, to assist vulnerable people living in their own homes and medicines to people living in residential and nursing homes.

Overall inspection outcome

Standards not all 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	Standards not all met	1.1	Standard not met	The pharmacy team do not manage and identify risk well.
		1.2	Standard not met	The pharmacy team do not follow company procedures.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy team is behind with their workload which indicates that something is going wrong with staffing levels and working rotas.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	There is evidence that some people may not be getting the advice that they should about their medicines.
		4.4	Standard not met	The staff cannot demonstrate that they act appropriatley to make sure that people only get medicines and devices that are safe.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team do not manage and identify risk well. All the dispensing areas are cluttered and disorganised. This increases the likelihood of mistakes. And, no specific actions are put in place following mistakes so that staff can learn from these to prevent them from happening again. The team do not follow company procedures which are designed to identify people who should be given specific advice. And they are not using the company procedures for medicines assembled into multi-compartment devices. The pharmacy team generally keep people's private information safe and the pharmacy is appropriately ensured to protect people if things go wrong. The team keep the up-to-date records that they must keep by law.

Inspector's evidence

The pharmacy team identified and managed some risks. But, there had been two dispensing errors in the previous two days. One was a quantity error where 4 Butec 5mcg patches had been supplied instead of 5, and the other, a labelling error where bisoprolol 2.5mg had been labelled as 5mg. The near miss log in the downstairs dispensary had only two recorded near misses for February 2019. One of these, on 25 February 2019, was a quantity error with tramadol 50mg. No learning points or actions taken to reduce the likelihood of a similar recurrence were recorded. No near misses had been recorded in the downstairs dispensary in March or April 2019. The company had introduced a new near miss log which was not being used either the downstairs or the upstairs dispensaries.

The downstairs dispensary was limited in size and at the time of the visit, cluttered (see attached photos). Several tubs, waiting to be checked, were stored on top of one another, some 10 high, in the checking area. This increased the likelihood of errors. In addition, the checking bench had some wholesale stock which needed to be put away. There were also four prescriptions waiting to be checked on the front bench. This posed a risk of accidential disclosure of confidential information. The upstairs monitored dosage system (MDS) room was disorganised (see attached photos). Stock to be put away in the upstairs domiciliary dosette (DDS) room was also disorganised (see attached photos). All these issues increased the likelihood of errors.

At the time of the visit, 14 DDS trays had to be assembled and checked for the next day. In addition, the pharmacy team were not following the company's new procedures for these trays (see further under principle 4). The medicines for two small homes, Primrose and The Vicarage should have been sent the afternoon of the visit but these were going to be delivered late, on Saturday (see further under principle 4).

When the inspector arrived at the pharmacy there was only one pharmacist, on a trail day, from another branch, who had never worked at the pharmacy before, working in the downstairs pharmacy. No one was covering the medicine counter. The dispensary telephone rang several times and was not answered.

Two assembled prescriptions were seen that had no 'pharmacist information forms' included. This was against the company's procedures. One of these was for a large quantity of gliclazide and the other

included, the schedule 4 controlled drug (CD), diazepam. The latter did not have a coloured CD card, as required by the company's procedures.

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. A new member of staff had been appointed, three weeks prior to the inspection. She was a NVQ2 trained dispenser but had not worked in a community pharmacy setting. She said that she would refer anything that she was uncertain of, to the pharmacist but she had not completed the company's Healthcare Way training for the sale of any medicines. In addition, the products that should be referred to the pharmacist under this system, such as fluconazole capsules, had not been highlighted on the shelves with dedicated 'care cards' to help inexperienced staff.

The pharmacy had a clear complaints procedure and feedback on all concerns was encouraged. The company operated a random feedback procedure and some till receipts gave instructions on how to provide feedback and raise concerns. An annual pharmacy specific customer satisfaction survey was also done, but the results for the latest survey were not available. The store manager said that the store received few complaints but there had been some feedback about waiting times. Because of this, the pharmacy tried to make sure that the medicine counter was attended and a member of the shop-floor had been enrolled on the medicine counter assistant training. However, as mentioned above, when the inspector arrived at the pharmacy, only the pharmacist was working in the downstairs dispensary and he had to also cover the medicine counter.

Current public liability and indemnity insurance was in place. The Responsible Pharmacist log, controlled drug (CD) records, private prescription records, emergency supply records, fridge temperature records and date checking records were all in order. One recent specials record seen did not have the details of the patient. Some of the patient-returned CD records had not been signed by a witness when they were destroyed.

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 understood safeguarding issues and most had completed the company's e-learning module on the safeguarding of both children and vulnerable adults. The pharmacist and technician had also completed the Centre for Pharmacy Postgraduate Education (CPPE). The company procedures to follow in the event of a safeguarding concern were printed off during the inspection. Local telephone numbers to escalate any concerns relating to children were available but not the number for vulnerable adults. The store manager gave assurance that this would be obtained. Most of the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing **Standards not all met**

Summary findings

It is unclear if there are enough staff at the pharmacy for it to safely provide the services it offers. But, the team is behind with their workload which indicates that something is going wrong. The pharmacy has lost some staff recently and not all have been replaced. Most of the services offered by the pharmacy are high-risk, to vulnerable people. The assembly of these medicines need extra care. This increases pressure on the team members. The company encourages its staff to keep their skills up to date. But, although compulsory learning is completed, other on-going learning is not routinely done. Team members studying towards recognised qualifications are allowed learning time. But, some new team members are not given the support that they should.

Inspector's evidence

The pharmacy was in a retail park close to the centre of Bristol. They dispensed approximately 11000 prescription items each month with the majority of these being repeats. 350 domiciliary patients and 400 care home patients (nursing and residential) received their medicines in monitored dosage systems (MDS). Few private prescriptions were dispensed.

The current staffing profile was 2 pharmacists during the week, except Thursday, 1 full-time (FT) accuracy checking technician (ACT), 3 FT NVQ2 trained dispensers, 4 part-time NVQ2 trained dispensers (1 not seen, on holiday), 1 FT NVQ2 trainee dispenser and 1 PT NVQ2 trainee dispenser. The store manager, also a trained dispenser, reported, that according to the company staffing algorithm, the store was over-staffed. However, as reported under principle 1, there was evidence that the pharmacy was behind with their workload. The clinical governance pharmacist also reported to the inspector that the pharmacy was over-staffed according to the company's staffing model.

The staff told the inspector that several staff had left recently, including a FT care home manager and an ACT. They said that many staff members had not been replaced. The second ACT had left two weeks before the visit. A third pharmacist had been recruited for three days, on the week before the visit, to mitigate the staffing situation. On the day of the visit, a pharmacist, on a trial day from another branch was seen to be working completely on his own for a time. He had no help in the dispensary and no one was covering the medicine counter. A regular pharmacist said that she worked on her own in the downstairs dispensary for about 3 hours each day. This increased the risk of errors. Some staff reported little help in the MDS and DDS rooms. Several staff told the inspector that the pharmacy had been chaotic over the last 6 weeks.

Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance development appraisal with a six-monthly review. The staff were encouraged with learning and development and were supposed to complete e-learning and 30-minute tutors. The store manager said that dedicated time was allowed for compulsory e-learning but that several staff had to be reminded to do this learning. All the staff said that they had insufficient time to complete the 30-minute tutors. Some staff did this in their own time. A new member of staff, a NVQ2 trained dispenser, but with no community pharmacy experience, said that she had only had 2 to 3 hours of induction where she was told to read the Standard Operating Procedures (SOPs). She had not completed all of these and said that she did not feel fully supported. The store manager said that people enrolled on accredited training courses, such as the NVQ2 dispensary assistant course were

allocated at least 30 minutes a week of protected time learning time towards their courses. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

Dispensary staff meetings had been held by the ACT who had left the pharmacy two weeks before the visit. She had also been responsible for the monthly patient safety review. The staff told the inspector that they used to help in which ever area was required according to workload pressure, until about 6 weeks ago.

The store manager reported that the pharmacist, on a trial day at the store, had been asked to do as many medicine use reviews (MURs) that he could because none had been done so far that week.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional but some areas are disorganised and cluttered. There is good signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. But, this room is some distance from the main dispensary which may discourage some people from using it.

Inspector's evidence

The pharmacy was well laid out. But, all dispensing areas were cluttered and disorganised (see under principle 1 and attached photos). The downstairs dispensary was small but upstairs there were large separate MDS and DDS rooms.

The consultation room was spacious and well signposted but located some distance from the downstairs dispensary which may discourage some people from using it. The room had a computer, a sink and three chairs. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and any 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. The medicines counter was located immediately adjacent to the pharmacy. Several non-healthcare items were sold.

Principle 4 - Services **Standards not all met**

Summary findings

People with a range of needs can access the pharmacy services and the store is open every day of the week. But, the pharmacy is behind with their workload and there is evidence that some people may not be getting the advice they should about their medicines. And, the staff cannot demonstrate that they act appropriatley to make sure that people only get medicines and devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with 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. The pharmacy was open every day of the week.

Advanced and enhanced NHS services offered by the pharmacy were medicine use reviews (MURs), new medicine service (NMS), supervised consumption of methadone and buprenorphine (5 patients), emergency hormonal contraception (EHC) and seasonal 'flu vaccinations. The latter was also provided under a private agreement as were malaria prophylaxis.

The regular pharmacists had completed suitable training for the provision of seasonal 'flu vaccinations 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 and the required training for the provision of the free NHS EHC service.

The pharmacy currently had 10 substance-misuse patients, 5 of whom had their medicines supervised. There was no dedicated folder for these patients and any concerns were not documented on their electronic prescription medication record. The regular pharmacist was not aware of the local shared care guidelines, the ROADS (Recovery Orientated Alcohol and Drugs Service) guidelines. The inspector sent her these. On the day of the visit, one prescription for supervised methadone was seen not to have been prepared in advance. This increased the likelihood of an error when the patient presented in the pharmacy. In addition, the cluttered downstairs dispensary (see photos and under principle 1), also increased the likelihood of an error.

Most of the business at the pharmacy was the assembly of medicines into monitored dosage systems (MDS). 350 domiciliary patients and 400 care home (nursing and residential) received their medication in MDS packs. These were assembled in separate spacious rooms upstairs.

The domiciliary dosettes (DDS) were assembled on a four-week rolling basis. There was a clear progress log of the entire process. There were dedicated folders for these patients. The company had recently introduced new procedures for the domiciliary trays. This required that, following any changes, a new sheet should be completed. The old sheets were supposed to be kept. The pharmacy was not using these new procedures. Some changes were seen that had not been dated. This meant that the checking pharmacist or ACT did not have a clear clinical history of the patient. An assembled dosette tray was seen for a female patient, aged 50, which contained sodium valproate. None of the staff in the DDS room were aware of the new guidelines for female patients of child-bearing age prescribed this.

The patient had not been counselled or sent the required advice leaflets.

As mentioned under principle 1, the assembly of the DDS trays was behind schedule. 14 trays needed to be assembled and checked on the day of the visit for delivery or collection the next day. One DDS tray was seen to be moved from the DDS room to the central bench of the MDS room for checking by the pharmacist. The ACT said that she was unable to check any DDS trays at the time of the visit because she was still waiting for them to be assembled.

The MDS room was spacious but, at the time of the inspection, the central bench was cluttered. There was no clear work priority (see attached photos). There were several interim items required to be checked for the afternoon delivery. These were not clearly marked as interims and not clearly separated from other work. The pharmacist said that the medicines for two small care homes should have been delivered that day but that the assembly of these had not yet been started. She said that the medicines would probably be delivered two days late. The pharmacist said the reason for this was that the homes had ordered the prescriptions late. She said that they had chased up the homes about the late prescriptions but she was unable to easily find the documentation of when this happened. This was because of new company procedures whereby all queries or communications were now written on individual sheets. The pharmacist was unable to locate the sheet detailing the query about the late prescriptions. In the past, communication diaries for each home were used. This made it easy locate any past issues.

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 which included some face-to-face training. The pharmacy staff gave any required advice over the telephone if necessary.

The pharmacy offered a managed repeat prescription service. However, the newly recruited NVQ2 dispenser had not yet received any training on this. She reported that she did not ask people, signed up to this service, to check when they collected their medicines, if they still needed everything that they had ordered the previous month. In addition, anyone not wanting an item was not routinely referred to the pharmacist for counselling. This meant that both, any wastage of medicines, and, any non-adherence concerns, may not be identified.

Medicines and medical devices were obtained from Alliance Healthcare, AAH and Boots Head Office. Specials were obtained from Alliance Specials. Not all stock was stored tidily (see attached photos and under principle 1). CDs were stored tidily in accordance with the regulations and access to the cabinets was appropriate. There were no patient-returned CDs but some out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with signatures recording who had undertaken the task. Doop bins were available for waste. The pharmacy staff were not aware of the Falsified Medicines Directive and the pharmacy had no scanners to check for falsified medicines.

There was said to be procedure for dealing with concerns about medicines and medical devices. But, none of the staff could report on any recent alerts and the latest alert in the folder was dated 11 July 2018 about valsartan. No actions regarding this had been 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 - 250ml). There were tablet-counting triangles, including separate dedicated ones 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.