General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit B4, Bentley Bridge Retail Park, Bentley, WEDNESFIELD, Wolverhampton, WV11 1BP

Pharmacy reference: 1090084

Type of pharmacy: Community

Date of inspection: 05/09/2019

Pharmacy context

This community pharmacy is located on a large retail park on the outskirts of Wednesfield. It dispenses prescriptions and sells a wide range of other health and beauty items. The pharmacy provides several NHS services including Medicines Use Review (MURs), the New Medicine Service (NMS) and emergency hormonal contraception (EHC). It also offers private services for malaria prophylaxis and the treatment of urinary tract infections (UTIs). Flu vaccinations are also available during the relevant season.

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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy team members complete structured ongoing learning to help to address any gaps in their knowledge.
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

The pharmacy identifies and manages risks appropriately. It keeps people's private information safe and maintains the records it needs to by law. Team members are familiar with their roles and responsibilities and they act to learn from their mistakes. They follow written procedures, which are regularly assessed, to help make sure they complete tasks safely and effectively. And they understand how to raise concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) covering operational tasks and activities. The procedures were regularly updated, and signature sheets were used to confirm staff acknowledgment and understanding. Team members completed 'test your understanding' questions and audits to help demonstrate their understanding of the procedures and make sure that they were embedded in everyday practice. Any identified issues were managed by the pharmacist in charge. The pharmacy had also recently had an additional audit carried out by the company's head office which involved the observation of procedures such as prescription handout and the sale of medications. Team members demonstrated a clear understanding of their roles and responsibilities, including discussing the activities which were permissible in the absence of a responsible pharmacist (RP). The pharmacy had professional indemnity insurance covering pharmacy services.

Pharmacy team members recorded their near misses, which were reviewed each month at a safety briefing. The pharmacist said that no major trends had been identified but explained some of the measures that had been taken in response to near misses, including using a tick method as a second check of strength and quantity, and the use of cautionary shelf-edge labels to encourage care with the selection of 'look alike, sound alike' medicines. These medications were also written on a pharmacist information form (PIF) as an additional prompt at the point of accuracy checking. The action taken in response to a recent incident was also discussed, and a record had been made electronically in line with procedures.

The pharmacy had an advertised complaint procedure. People using pharmacy services were able to provide feedback verbally and also through survey cards which were available near to the till point. Further feedback was obtained through a Community Pharmacy Patient Questionnaire (CPPQ) which was ongoing at the time of the inspection. Previous feedback was positive.

The correct RP notice was conspicuously displayed near to the medicine counter. The RP log was compliant with requirements, as were emergency supply records. There were occasional records for the supply of private prescriptions which recorded the name of the prescriber incorrectly, and specials procurement records did not always provide an audit trail from source to supply. So, the pharmacy may not always be able to show what has happened in the event of a query. Controlled Drug (CD) registers were in order and kept a running balance. Regular checks were carried out to identify discrepancies. Patient returned CDs were recorded in a designated register and previous destructions were signed and witnessed.

Pharmacy team members had completed information governance training and they discussed how they would help to protect people's privacy in the pharmacy. Completed prescriptions were stored out of public view and confidential waste was segregated for appropriate disposal. Pharmacy team members were in possession of their own NHS smartcards and appropriate use was seen on the day.

All pharmacy team members had completed a safeguarding e-Learning module and the pharmacist had undertaken additional training through the Centre for Pharmacy Postgraduate Education (CPPE). The contact details of local safeguarding agencies were available to support the escalation of the concerns and a dispenser discussed some of the types of concerns that she might identify. The pharmacy's chaperone policy was advertised in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members hold the appropriate qualifications for their roles. They complete ongoing training to keep their knowledge up to date and get regular feedback on their development so that they can learn and improve their practice. The pharmacy enables its team members to provide feedback and it has a whistleblowing policy for anonymous concerns.

Inspector's evidence

On the day of the inspection, the regular pharmacist was working alongside a qualified dispenser. A second qualified dispenser arrived midway through the inspection and a third towards the end. The pharmacy also employed an additional dispenser, a pre-registration pharmacist and a pharmacy student, none of whom were present. Team rotas were planned so that more staff members were present during the core working hours of the day to help with service provision and tasks were also planned, to ensure that they were all completed in good time. The team felt that the workload in the pharmacy was generally manageable. They were up to date with dispensing and deliveries were being made on time. But the environment could sometimes get busy, with staff required to cover both the prescription and healthcare counters. This meant that they were sometimes interrupted when completing tasks which may increase the likelihood of mistakes. Leave in the pharmacy was planned and cover was usually arranged within branch. Several team members worked part-time and could increase their hours to provide support. Members of store management were also pharmacy trained or enrolled on an appropriate training programme enabling them to offer additional assistance.

Team members were appropriately trained for their roles and an assistant manager was enrolled on a training programme through the company. Arrangements had been made to make sure that the assistant manager was provided with sufficient time in the dispensary to complete the training course. Further staff training was available through an e-Learning system. Staff completed topics such as information governance, health and safety and other healthcare-based modules. Monthly tutor programmes were also issued which covered a range of over-the-counter (OTC) conditions and treatments. Protected learning time was provided, and training records were kept as an audit trail. Any further updates were cascaded through a professional standards bulletin which was issued each month and read by staff. The pharmacist discussed the pre-registration training programme, which involved the completion of tasks which were reviewed by the pharmacist and attendance at regular study days. The pharmacist was the designated pre-registration tutor and held a monthly development review with the pre-registration pharmacist. General team development was monitored through regular appraisals with the store manager. Input was provided by the pharmacist to help make sure that any development needs were adequately identified and addressed.

Sales of medicines were discussed with a dispenser who identified the types of questions that she might ask to make sure that sales were safe and appropriate. The questioning approach was seen to be adopted by all team members for sales that took place during the inspection. The dispenser was aware of medications which required referral to the pharmacist, such as requests for EHC and Viagra Connect. She also identified other concerns such as repeated requests for medicines and highlighted some

medications which may be susceptible to abuse.

The team worked well together and were comfortable discussing any concerns that they may have. They were happy to approach the regular pharmacist, who had just received a 'regional pharmacist of the year' award following nomination from team members. The team were also able to provide feedback through a regular staff survey. They were provided with some feedback from this, but previous feedback on the lack of designated healthcare counter cover had not been acknowledged and they were not aware of any action that had been taken in response to this. The pharmacy had a whistleblowing policy, but there were some team members who were unsure of how they could escalate an anonymous concern. The pharmacist agreed to make sure that all team members were familiar with the procedure and make the relevant details visible within the pharmacy.

There were targets in place for services such as MURs. The pharmacist discussed how she would identify people who may be suitable for services and said that team members asked questions to help identify people who may be struggling with their medicines. Service provision was then reviewed alongside other workload activities to help make sure that safety was not compromised.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional and secure environment for the provision of healthcare services. And it has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions.

Inspector's evidence

The pharmacy was well maintained and portrayed a professional appearance. It was clean and tidy on the day, with most house-keeping duties being completed by pharmacy team members. Support with cleaning the floor was provided through a store cleaner. Maintenance concerns were reported to the company's head office who arranged for any necessary repairs. There was adequate lighting throughout the premises and air conditioning maintained a temperature which was suitable for the storage of medicines.

The front of the premises stocked a wide range of health and beauty items which were suitable for a healthcare-based business. The aisles were free from obstructions and there were various promotional displays throughout. The pharmacy was located at the rear of the premises. Pharmacy restricted medicines were placed behind the healthcare counter to help prevent self-selection and several chairs were placed nearby for use by people less able to stand. The dispensary was located to the side of the healthcare counter and was compact. There was a front counter which was used by patients handing in and collecting prescriptions. To the side of this was a dispensing terminal and a small work area. A privacy screen was fitted around the station to help make sure that confidential information was not visible. Further work bench space was available in the dispensary, with a designated checking area in place. There was good use of shelving and drawers which kept the work benches free from unnecessary clutter. There was also a sink for the preparation of medicines, which was equipped with appropriate hand sanitisers.

In front of the dispensary was an enclosed consultation room. The room was fitted with a glass door and a curtain was used to afford privacy. The room was equipped with a desk and seating to facilitate private and confidential discussions and it was signposted from the retail area. No confidential information was visible on the day.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources and stores medicines appropriately. Its services are well managed and organised so that people receive appropriate care. And team members make extra checks to make sure that people on high-risk medicines receive the information they need to take their medicines properly.

Inspector's evidence

The pharmacy was located on a retail park. The entrance to the premises was step-free and automatic doors were fitted to aid those with mobility issues. The prescription counter was situated at the rear of the pharmacy and was easily locatable through clear signage. Additional adjustments could be made for people with different needs. The pharmacy had a hearing loop device and large-print labels could be printed from the patient medication record (PMR) system.

Pharmacy services were advertised in a practice leaflet, which was available for selection. Other promotional materials advertised the upcoming flu season and travel services. Several other health promotion leaflets were located near the consultation room and provided information on mental health and the appropriate use of antibiotics. People who required other services were directed to the relevant healthcare providers. The team had a general awareness of services located in the local area and internet access was also available for further information. Records of signposting were not routinely maintained as an audit trail.

Prescriptions in the pharmacy were kept separate to reduce the risk of medicines being mixed up. Cards were used to highlight prescriptions for people who were waiting, and the team kept an audit trail for dispensing using ‘dispensed’ and ‘checked’ boxes. A quadrant stamp was also used on each prescription form to record the details of a clinical check and prescription handout. Each prescription form was accompanied by a PIF, which identified any patient who may be suitable for a service, highlighted ‘look alike, sound alike’ medicines for additional checks, and any other important points such as dose changes or communications from the GP.

The pharmacy used stickers to highlight prescriptions for CDs, they recorded the date of expiry to help make sure that supplies were made within the valid 28-day requirement. Prescriptions for high-risk medicines were highlighted using cards and some records of monitoring parameters such as INR readings were kept. The supply of valproate-based medications to people who may become pregnant was discussed. The pharmacist was aware of the recent guidance issued by the Medicines and Healthcare products Regulatory Agency (MHRA) and during the inspection she was observed to print copies of the necessary warning literature for a walk-in patient who met the cautionary criteria.

The pharmacy provided a prescription collection service. Patients identified the medications which were required each month and dates were calculated for reorder and supply. Team members kept an audit trail of prescriptions which were sent off and received back from the surgeries so they could follow-up on unreturned requests. Prescription requests for patients receiving multi-compartment compliance aid packs were managed in the same way. Each patient had a master record of medication,

which was amended as an audit trail for any medication changes. Compliance aid packs contained descriptions of individual medicines and patient leaflets were supplied. The pharmacist discussed the conversation that she would have with any patient who requested a new compliance aid pack. She provided a recent example where the conversation had identified other suitable ways in which the patient could be assisted with their medicines and this was being successfully managed by the pharmacy.

Signatures were obtained to confirm the delivery of medicines. And failed deliveries were returned to the pharmacy. The pharmacist discussed upcoming changes to the delivery service, which had been discussed with patients verbally and written information had also been provided.

The pharmacist had completed training for the provision of EHC and discussed the way in which a difficult consultation had previously been managed to provide reassurance to the patient. A signed copy of the in-date patient group directive (PGD) was available for reference. The pharmacy had recently begun to offer a UTI treatment service. Patients brought a test kit which analysed a urine sample. The results of this were sent to the pharmacy for review by the pharmacist, and a supply of an antibiotic was made in accordance with an in-date PGD, where this was appropriate. The pharmacist was unsure of any antibiotic sensitivity analysis and explained that patients still presenting with symptoms after treatment were immediately referred. The service was relatively new and had received limited uptake thus far. The travel service provided malaria prophylaxis treatment. The pharmacist conducted a consultation using 'know malaria' resources and a private prescription was provided for the most appropriate treatment, which was then supplied from the pharmacy. People using the service were also provided with additional guidance information on the prevention of malaria.

Stock medications were sourced from reputable wholesalers and specials from a licensed manufacturer. Stock was stored in an organised manner and was kept in the original packaging provided by the manufacturer. Regular date checks were undertaken, and short-dated medicines were highlighted and removed from the shelves each month. No out of date medicines were identified from random samples. Returned and obsolete medicines were placed in designated waste bins. The pharmacy received electronic alerts for the recall of faulty medicines and medical devices and they kept an audit trail to demonstrate the action taken in response to alerts. It was not currently compliant with the requirements of the European Falsified Medicines Directive (FMD). The team had received some training and were awaiting further instructions and updates from the company's head office.

CDs were stored appropriately with returned and out of date CDs segregated from stock. Random balance checks were found to be correct and CD denaturing kits were available. The pharmacy fridge was fitted with a maximum and minimum thermometer and the temperature was checked and recorded each day. It was within the recommended temperature range during the inspection and no recent deviations had been recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the facilities and equipment it needs to provide its services safely. And its team members understand the need to protect people's privacy when using equipment.

Inspector's evidence

The pharmacy had access to paper pharmaceutical reference texts including the British National Formulary. Internet access supported additional research, as did a Medicines Complete subscription. A range of glass crown-stamped measures were available with separate measures marked for use with CDs. Counting triangles and capsule counters were clean and well maintained, with a separate triangle reserved for use with cytotoxic medicines.

Electrical equipment had been PAT test approved until January 2020 and was in working order. Computer systems were password protected. The screen on the main dispensing terminal was surrounded by a privacy screen. A second terminal, which was not usually used for dispensing faced away from the counter and team members were observed to take care to minimise the screen so that no patient identifiable data was left visible on the day. The main telephone in the pharmacy was corded and was located just inside the dispensary and near to the counter area, where the computer system was also located. This may increase the risk that some conversations may 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.