General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 6 Prestatyn Shopping Park, Nant Hill Road, PRESTATYN, Clwyd, LL19 9BJ

Pharmacy reference: 1117505

Type of pharmacy: Community

Date of inspection: 04/04/2019

Pharmacy context

This is a busy community pharmacy located on a retail park, in the seaside town of Prestatyn, North Wales. The pharmacy premises are easily accessible for people, with an automated entrance door and wide aisles in the retail area. The pharmacy has a large retail area, sells a range of over-the-counter medicines and dispenses NHS prescriptions. It is situated a five minute walk away from two GP practices.

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	The pharmacy records and analyses adverse dispensing incidents to identify learning points which are then incorporated into day to day practice to help manage future risk.
		1.7	Good practice	Members of the pharmacy team receive information governance training. They get regular refresher training and assessment to provide assurance that they understand their responsibilities.
2. Staff	Good practice	2.2	Good practice	Members of the pharmacy team have protected time to learn while they are at work.
		2.4	Good practice	The manager supports the pharmacy team to identify and address their learning and development needs.
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 manages the risks associated with its services and protects people's information well. It asks people for their views and makes sure it uses this feedback to improve its services. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them. And act to help stop the same sort of mistakes from happening again. The team members complete training so they know how to protect children and vulnerable adults and people’s welfare.

Inspector's evidence

An audit stamp that includes who clinically checked, dispensed, accuracy checked and handed out was routinely being used on prescriptions.

Professional standards bulletins were regularly provided by head office and the pharmacy staff read and signed each bulletin.

Fridge medicines were dispensed into clear bags and an assembled prescription for insulin that was awaiting collection was stored in the fridge in a clear bag. A pharmacy advisor explained that the insulin box was shown to the patient upon collection to clarify it was what they were expecting.

A pharmacist explained that a pharmacist information form (PIF) was available and he said they were used with all assembled prescriptions to convey information to the pharmacist such as a change in dose. Assembled prescriptions awaiting collection had a PIF included.

There were up to date standard operating procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. Roles and responsibilities of staff were set out in SOPs. A pharmacy advisor was seen to be following the SOPs that were relevant to her role and she was able to clearly describe her duties.

The pharmacy manager had created a list of pharmacy accountabilities (tasks), with specific tasks allocated to individual team members. The tasks included a wide range of areas such as patient safety, clinical governance, mail bags, CD balances, services targets and claims, appointments, model day, operations, NHS alerts, stock, training, FRPS, customer service and weekly briefing. The pharmacy manager said by having the list of tasks to be completed, it ensured that all pharmacy tasks were completed on an ongoing basis, even when team members were off work. A pharmacy advisor said she thought the list of tasks allocated was a useful way of making sure tasks were completed. Some pharmacy tasks were included on the staff rota each day, with time to complete the task allocated. i.e. owings and stock, match up – dispensing support pharmacy (DSP), DSP entry, training, order pad and end of day.

Dispensing incidents were reported on the 'piers' computer system and learning points were included. Near misses were reported on a near miss log in the dispensary. The near misses were discussed with the pharmacy team member at the time. The pharmacy manager who was in the process of completing the NVQ level 3 to become a pharmacy technician was the patient safety champion and reviewed the near miss log each month. Detailed near miss records were provided. The staff were expected to read

the action plan (patient safety review) that had been produced because of reviewing the near miss log, dispensing errors or key issues that needed to be discussed. The pharmacy manager demonstrated that because of a previous near miss error with different formulations of ramipril, the stock had been highlighted.

Several look alike sound alike (LASA) stock medicines were highlighted, by a sticker being attached to the dispensary shelf where the stock was stored. The pharmacy manager explained that the LASA medicines had been identified across the organisation as being at an increased risk of a near miss or dispensing error. i.e. amitriptyline and amlodipine, quetiapine and quinine, atenolol and allopurinol. She said that each time a LASA medicine was dispensed, it was highlighted on a PIF. An example of this was observed amongst the assembled prescriptions awaiting an accuracy check.

The correct responsible pharmacist (RP) notice was displayed prominently in the pharmacy.

A pharmacist explained that he aimed to resolve complaints in the pharmacy at the time they arose, although he referred the customer to the store manager and or head office if they felt it was unresolved or he felt it was necessary.

A customer satisfaction survey was carried out annually and the results of the previous survey were displayed in the consultation room. The pharmacy manager explained that some patients had provided negative feedback regarding the waiting time for their prescription to be dispensed. As a result, the pharmacy had created two separate queues at the counter for prescription collection and prescription drop off.

The company had appropriate insurance in place.

The private prescription record, emergency supply record, specials procurement record, responsible pharmacist (RP) record and the CD registers were in order. Records of CD running balances were kept and these were audited regularly. Patient returned CDs were recorded and disposed of appropriately.

Confidential waste was being collected in a designated bin to be collected by an authorised carrier. Patient information was kept out of sight of patients and the public. The staff had completed confidentiality training as part of their mandatory information governance training on e-learning, which was completed annually. Computers were all password protected and faced away from the customer. Assembled prescriptions awaiting collection were being stored on shelves in the dispensary in a manner that protected patient information. A privacy notice was displayed in the pharmacy.

The pharmacy manager said that all staff had completed level 1 safeguarding training on e-learning. The contact numbers required for raising safeguarding children and adult concerns were displayed in the dispensary. The accuracy checking pharmacy technician (ACPT) had completed the in house safeguarding level 1 training and WCPPE level 2 safeguarding training. Both pharmacists had completed level 2 safeguarding training. The pharmacy manager said she was not aware of any safeguarding concerns that had been dealt with in the pharmacy.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough pharmacy team members to manage its workload safely. The team members are well trained and work effectively together. They are comfortable about providing feedback to their manager and receive feedback about their own performance. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was a locum pharmacist who had not worked in the pharmacy before and was signed in as responsible pharmacist (RP), a second relief pharmacist who commenced her role towards the end of the inspection, a relief accuracy checking pharmacy technician (ACPT), a pharmacy manager who was undertaking the NVQ level 3 to become a pharmacy technician, three pharmacy advisors, two trainee pharmacy advisors and a trainee healthcare partner on duty at the time of inspection.

The staff were very busy providing pharmacy services throughout the inspection. They appeared to work well together as a team and manage the workload adequately.

The staff used the intranet e-learning to ensure their training was up to date. A pharmacy advisor said they were expected to complete training on an ongoing basis and she had completed a training module on information governance in the last month. The staff in the dispensary said the pharmacy manager was very supportive with learning and she was more than happy to answer any questions they had. A pharmacy advisor said the pharmacy manager allowed staff sufficient time to complete training in work, with staff members allocated one hour each week on the rota for training purposes.

The staff were aware of a whistle blowing policy in place and were happy to report concerns about a member of staff if needed. Details outlining the policy were available in the pharmacy for staff to refer to.

Staff were provided with feedback informally from the pharmacy manager. i.e. near miss errors, outstanding training and any issues in their role.

A trainee healthcare partner covering the counter was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as Nytol. i.e. she referred the patient to the pharmacist for advice and support.

The pharmacy manager explained that there were targets in the pharmacy and she had not felt under any organisational pressure to achieve these. She said there was no compromise to patient safety or the quality of services provided because of the targets and the only consequence of not hitting a target may involve a supportive discussion with the area manager to ascertain why the target was not met.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare.

Inspector's evidence

The pharmacy's retail area was clean and tidy. The retail area was free from obstructions and had a waiting area. The dispensary benches, the sink and floors were cleaned regularly and a cleaning rota was available.

The temperature in the pharmacy was controlled by air conditioning and heating units. Lighting was adequate. Staff facilities included a microwave, toaster, kettle and fridge, separate ladies and gents WC with wash hand basins and antibacterial hand wash.

The pharmacy premises were maintained and in a generally adequate state of repair. Maintenance problems were added to a maintenance log and reported to head office via the 'one number'. There were some broken shelves in the retrieval area that had been reported on the maintenance log and were to be replaced.

There was a locked consultation room available which was uncluttered, clean and professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed, so people receive their medicines safely. The pharmacy takes extra care when supplying some medicines which may be higher risk. The pharmacy sources and stores medicines safely and carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible, including patients with mobility difficulties and wheelchairs.

There was a hearing loop in the pharmacy which was in working order.

The pharmacy offered amongst other services, a common ailments scheme to increase the accessibility to patients. There was a selection of healthcare leaflets in the retail area for customers. Staff were clear about what services were offered and where to signpost to a service if this was not provided. i.e. travel vaccinations.

The opening hours were displayed near the entrance to the pharmacy. A list of services provided was displayed in the pharmacy.

A pharmacy advisor explained that CDs awaiting collection had a laminated CD label and CD expiry date sticker included on the bag and with the prescription. She explained that this was to ensure that it was not handed out after 28 days of the prescription date. An example of this was seen for a schedule 2 CD stored in a CD cabinet. She said all schedule 3 and 4 CDs were highlighted with a CD expiry date sticker and a prescription awaiting collection for a schedule 3 CD had been highlighted in this manner.

The pharmacy manager explained that laminated cards for warfarin, methotrexate and lithium were kept with assembled prescriptions in the prescription retrieval system. She said this was to enable the pharmacist or pharmacy advisor to provide the appropriate counselling when handing out the prescription. A prescription for warfarin awaiting collection was seen with the respective laminated card. She said that patients prescribed warfarin were asked to provide a copy of their latest INR results in order to record them on the patient medication record (PMR). A warfarin patient's medication record was reviewed and they had their INR reading documented in October 2018.

The pharmacy had patient information resources for the valproate alert, including, patient cards, patient information leaflets and warning stickers. The pharmacy had carried out an audit for patients prescribed valproate and had identified four people who may become pregnant prescribed valproate. One of the patients had a pregnancy prevention plan (PPP) in place and the other patients had a discussion with the pharmacist and were referred to their GP for review.

The work flow in the pharmacy was organised into separate areas – four dispensing stations in the galley area, dispensing bench space and a designated checking area for the pharmacist.

Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Plastic containers were used in the dispensary to reduce risk of medicines becoming mixed up.

The ACPT explained how the dispensing support pharmacy (DSP) service worked in the pharmacy, which was in accordance with the SOP. Each prescription was clinically checked by a pharmacist and the computer data entry was completed by a pharmacy team member. Once the dispensed prescriptions were received back in the pharmacy from the DSP, a pharmacy team member matched up the prescription with the assembled bag of medication and this was placed into the retrieval area in the same manner as prescriptions dispensed in the pharmacy. The pharmacy manager said that approximately 60% of repeat prescriptions were now dispensed offsite at DSP.

The pharmacy manager explained how the prescription delivery service was provided. Designated shelving in the dispensary was used for assembled prescriptions requiring delivery. All prescription deliveries were electronically signed for by the patient. The pharmacy manager said any patients who were not at home when the delivery driver attempted delivery were left a note advising them of the delivery attempt and the medicines were returned to the pharmacy for safe keeping. A separate CD delivery note was used for the delivery of all CDs requiring safe custody and this included an audit trail of supply between the pharmacist, pharmacy, the delivery driver and the patient. Copies of completed CD delivery notes were provided. A communications diary was used by the pharmacy team to pass on information regarding the delivery service and the patients who used this service.

Patient returned CDs were destroyed using denaturing kits and records made in a designated book. A CD key log was available. A balance check for a random CD was carried out and found to be correct.

The pharmacy manager said she was aware of the Falsified Medicines Directive (FMD). She said currently they had no FMD SOP in place, there had been no FMD staff training and there was no FMD computer software or scanning equipment in place. Some of the staff spoken to were unaware what FMD was.

Date checking was carried out and documented. Short-dated medicines were highlighted with a short-dated sticker added to the medicine and the expiry date written on. No out of date stock medicines were seen from a number that were sampled.

Stock medications were sourced through licensed wholesalers and specials from a specials manufacturer.

The date of opening for liquid medicines with limited shelf life was seen added to the medicine bottles.

Alerts and recalls etc. were received via the intranet. These were read, acted on by the pharmacist or pharmacy team member and a record was kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide the service safely.

Inspector's evidence

Paper copies of the BNF and BNFc were available. The staff used the intranet and internet to access websites for up to date information. i.e. medicines complete.

There were two clean fridges for medicines with minimum and maximum thermometers. The minimum and maximum temperatures were being recorded daily and the records were complete.

Any problems with equipment were reported to the head office maintenance department. All electrical equipment appeared to be in working order. According to the PAT test stickers attached, the electrical equipment had been PAT tested in March 2019.

There was a selection of liquid measures with British Standard and Crown marks. Designated measures were used for CDs.

The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles and a capsule counter.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy.

Cordless telephones were available in the pharmacy and the staff said they used these to hold private conversations with patients when needed.

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.