

Registered pharmacy inspection report

Pharmacy Name: Boots, 89-95 Crockhamwell Road, Woodley,
READING, Berkshire, RG5 3JP

Pharmacy reference: 1028967

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

This is a community pharmacy located in the centre of the town of Woodley, a suburb of Reading in Berkshire. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), the supply of Champix for smoking cessation and seasonal flu vaccinations. And, it provides multi-compartment compliance aids if people find it difficult to take their medicines on time. The pharmacy also provides medicines to residents in care homes.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
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

Overall, the pharmacy manages risks adequately. Members of the pharmacy team monitor the safety of their services by recording their mistakes and reviewing them. But, they don't always put the learning from them into practice to prevent similar mistakes happening in future. The pharmacy protects people's private information appropriately. And, it maintains most of its records in accordance with the law. But some details about private prescriptions and emergency supplies are missing from its records. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

This was a busy pharmacy and the workload was being managed in an adequate manner. The pharmacy's dispensing activity occurred from three distinct areas as described under Principle 3 and 4. There were documented standard operating procedures (SOPs) to support the provision of the pharmacy's services. Some of them were reviewed in 2017, 2018 and 2019. The staff had read and signed the SOPs, they understood their roles, responsibilities and limitations and knew when to refer to the pharmacist. Team members roles and responsibilities were defined within a completed matrix. The correct notice for the responsible pharmacist (RP) was on display and this provided people with details of the pharmacist in charge of operational activities on the day.

The store manager completed weekly clinical governance checks to ensure certain systems and processes were in place. A notice board was used to attach prescriptions and manage the workload in the main dispensary, one member of staff processed walk-in prescriptions, others dealt with call-backs and repeat prescriptions. Look-alike and sound-alike medicines were identified. Staff used laminated cards to highlight higher-risk medicines and attached pharmacist information forms (PIFs) to prescriptions when assembling them. This provided relevant information when checking medicines for accuracy or handing out prescriptions. However, there were PIFs missing on checking the retrieval system for dispensed prescriptions awaiting collection.

Staff recorded their near misses in all the dispensaries. They were collectively reviewed every month by one of the pharmacists. The company's Patient Safety Review (PSR) was completed, and details were shared with the team. An annual patient safety review was also completed with key learning points recorded within this. One member of staff described highlighting allergies, the names of the residents and the dates of their births when processing interims for the care homes in response to a previous incident that involved an incorrect person's details. This had reduced the likelihood of this happening again. However, although near misses were routinely recorded and reviewed, the reason for the errors were consistently recorded as 'lack of self-checking' every month. This was seen for both the care home dispensing and in the main dispensary. The pharmacy's PSR every month then recorded that staff were not routinely 'self-checking' during the accuracy-checking procedure. There was no evidence that any of the pharmacy's or the team's procedures had been changed in response to this.

Incidents were handled by the pharmacists or the store manager and investigated by the latter. The process was in line with the company's requirements and involved information being recorded on their internal reporting system. At the point of inspection, the pharmacy did not display information about its complaints procedure. This meant that people may not have been able to provide feedback or raise concerns easily. Staff had routinely marked in the pharmacy duty folder that the practice leaflet was on display.

Team members were trained as dementia friends and could identify signs of concern to safeguard vulnerable people. Most of them had completed the company's e-Learning module. Pharmacists were trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy's chaperone policy was on display on the consultation room door. There were local contact details for the safeguarding agencies and policy information present although some staff were unaware this existed, and the details seen were dated. The store manager was advised to check and obtain the most up-to-date details.

There was no confidential material left within areas that faced the public. Staff segregated confidential waste before this was disposed of through the company and details on dispensed prescriptions awaiting collection were not visible from the retail area. The team was trained on information governance and the European General Data Protection Regulation (GDPR) through completing the relevant e-Learning modules. Summary Care Records were accessed for emergency supplies and consent for this was obtained verbally. At the point of inspection, the pharmacy was not informing people about how their privacy was maintained. Once highlighted, the store manager printed a copy of the company's privacy notice for this to be displayed, once it was laminated.

Some of the pharmacy's records were maintained in line with statutory requirements. This included the RP record, records of unlicensed medicines and a sample of registers seen for controlled drugs (CD). For CDs, balances were checked and documented every month generally. On randomly selecting CDs held in the cabinet, their quantities matched entries in corresponding registers. There were incorrect prescriber details and the types of prescribers seen recorded in the electronic register for private prescriptions and the nature of the emergency when providing emergency supplies was not routinely being documented.

The maximum and minimum temperatures for the fridges were checked every day and records were maintained to verify that temperature sensitive medicines had been stored appropriately. Paperwork for the Champix service was present and had been signed by the authorised pharmacists. The pharmacy held appropriate professional indemnity insurance arrangements to cover the services provided. Staff kept a record of CDs that were returned by people and destroyed by them although some of the records were on loose pieces of paper and there were some missing details within the company's pharmacy duty records.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has an adequate number of staff to manage its workload safely. Pharmacy team members in general, understand their roles and responsibilities. They keep their skills and knowledge up to date by completing regular training.

Inspector's evidence

There were usually two pharmacists, one of whom worked in the main dispensary and the other was also the store manager. Staff present during the inspection included nine pharmacy advisors, one of whom was enrolled in accredited training but due to leave employment soon, another who was a pharmacy student and a third member of staff who was enrolled onto accredited training for the NVQ 3 in dispensing. Three pharmacy advisors worked in the care home dispensary and one was responsible for dispensing the compliance aids. Two were present on the pharmacy counter and the remainder worked in the main dispensary. Other staff included a part-time accuracy checking technician (ACT), another regular pharmacist responsible for the care homes and a pharmacy advisor who was also enrolled on the NVQ 3 in dispensing. The pharmacy was currently recruiting for another ACT.

There was also a customer advisor present in one of the upstairs dispensaries, she explained that her role involved mostly admin work such as filing but she also handed out dispensed prescriptions that were awaiting collection. This member of staff had read the pharmacy's SOPs and knew which activities were permissible in the absence of the RP. The GPhC's minimum training requirements were discussed at the time. Name badges were worn by staff although certificates for the team's qualifications obtained were not seen. Staff asked some relevant questions before they sold over-the-counter (OTC) medicines, if they were unsure. they asked the RP and they demonstrated some knowledge of OTC medicines.

To assist with training needs, staff described using resources from the company such as the e-Learning modules and they read SOPs. Team members in training described receiving protected learning time. Members of the pharmacy team received formal appraisals every six months. Details and updates were regularly conveyed to the team through regular huddles every week and communication books were used. The store manager explained that there was an expectation to complete 250 MURs, this was described as manageable.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are secure and provide an appropriate environment to deliver its services. And, it has a separate area where confidential conversations and services can take place.

Inspector's evidence

The pharmacy premises consisted of a spacious retail area with three dispensaries in the building. Two of them were located upstairs and were used to prepare medicines for the care homes and the compliance aids. The main dispensary was situated downstairs in front of the main entrance. There was also a carousel here to store some of the medicines. There was an adequate amount of workspace available in the latter to process and assemble prescriptions. There was more space in the other two dispensaries in line with their workload. Entry into the latter areas could be restricted using key coded access.

The retail space and all three dispensaries were generally clean. The fixtures and fittings however, in the pharmacy were dated which gave the opposite impression. The pharmacy was appropriately presented, suitably bright and ventilated. A signposted consultation room was available for services and private conversations. It was locked when not in use and the space was of an adequate size for the services. Pharmacy (P) medicines were stored behind the front counter and staff were always present to restrict their self-selection.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally provides its services in a safe manner. The pharmacy obtains its medicines from reputable sources and stores most of them appropriately. But, it has no separate containers to store and dispose of some medicines that could be harmful to the environment. And, team members don't always record information when people receive higher-risk medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

The pharmacy could be accessed at street level through the wide, front double doors. There was clear space outside the main dispensary/front counter area and wide aisles throughout the store. This helped people with wheelchairs to easily access the pharmacy's services. Two seats were available for people waiting for prescriptions or services. Staff described speaking clearly and facing people who were partially deaf. A hearing aid loop was also available. They explained details verbally to people who were visually impaired and physically assisted them. Some members of the team spoke Arabic, French, Spanish and languages from Ghana such as Twi and Ga for people whose first language was not English. Staff signposted people to other organisations from online information and from documented details that were present. The latter were however dated.

During the dispensing process, trays were used to hold prescriptions and medicines once assembled and the team used dispensing audit trails to identify staff involved in various processes. This was through a facility on generated labels as well as a quad stamp on prescriptions.

People prescribed higher-risk medicines were identified, counselled and relevant parameters were checked. This included asking about and obtaining relevant information for residents in the care homes. The team asked about the International Normalised Ratio (INR) level for people prescribed warfarin. However, this information was not retained or routinely recorded. Some records for people receiving compliance aids were from 2018 and there was intermittent recording of relevant details happening in the main dispensary. Staff were aware of the risks associated with valproates. The pharmacy had completed an audit in the past to identify females at risk and relevant people were counselled. There was also literature available to provide to people.

The team stored prescriptions once they were assembled within an alphabetical retrieval system. Fridge items and CDs (Schedules 2-3) were identified using stickers, PIFs and laminates. Schedule 4 CDs were not routinely identified. This meant that some staff such as the customer advisor may not have known that some prescriptions were only valid for 28-days. Assembled CDs that required safe custody and fridge lines were stored within clear bags, this helped assist in identifying them when they were handed out. Uncollected medicines were removed every five weeks.

Compliance aids: Medicines were supplied to around 300 people within compliance aids after the person's suitability for them was assessed by the RP. The pharmacy ordered prescriptions on behalf of some people and details on prescriptions were cross-referenced against individual records to help identify changes or missing items. They were checked with the prescriber and audit trails were maintained to verify this. Patient information leaflets (PILs) were routinely supplied, descriptions of medicines were provided, and all medicines were de-blistered into the compliance aids with none left within their outer packaging. Mid-cycle changes involved them being retrieved and supplying new ones.

Care homes: Medicines were provided to over 40 care homes with capacity for around 500 to 600 residents. These were supplied as original packs of medicines. If the care homes requested repeat prescriptions, a duplicate copy of the Medication Administration Record (MAR) detailing the requests was provided and prescriptions were checked against this to ensure all items had been received. A missing items form was faxed to the care home if items were outstanding. Interim or mid-cycle items were dispensed at the pharmacy. PILs were routinely supplied. Staff had been approached to provide advice regarding covert administration of medicines to care home residents and they maintained documented details to verify this. A three-way conversation and agreement were required between the pharmacy, care home or representative(s) and the person's GP. Relevant guidelines and resources were used to assess the suitability for this.

Delivery: The pharmacy provided a delivery service and it kept records to help demonstrate and verify the process. CDs and fridge items were highlighted. People's signatures were obtained when they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy with notes left to inform people about the attempt made and medicines were not left unattended.

The pharmacy obtained its medicines and medical devices from licensed wholesalers such as Alliance Healthcare, AAH and Phoenix. Unlicensed medicines were obtained through Alliance. Staff were unaware about the processes involved for the EU Falsified Medicines Directive (FMD). The pharmacy was not yet set up to comply with the process and there was no relevant equipment present or guidance information for the team.

Most of the medicines in the main dispensary were stored in an organised manner. There were the occasional loose blisters of medicines seen in the upstairs dispensaries and the occasional poorly labelled container present in the main dispensary when medicines were stored outside of their original containers. Stock was date-checked for expiry every three months and schedules were in place to verify the process. This showed that some sections of medicines were checked every month. Short-dated medicines were identified using stickers. There were no mixed batches or date-expired medicines seen. Liquid medicines when opened, were marked with the date that this took place.

Medicines requiring cold storage were stored appropriately in the fridges. CDs were stored under safe custody. Keys to the cabinet were maintained in a manner that prevented unauthorised access during the day and overnight. There was also a CD key log in use for this. Drug alerts were received through the company system. The process involved checking for stock, acting as necessary and staff passed relevant information to the care homes. A full audit trail was present to verify the process.

Medicines brought back by people for disposal were stored within designated containers. However, there was no separate container available to dispose of hazardous or cytotoxic medicines and no list for the team in the main dispensary to readily identify these medicines. People returning sharps for disposal, were referred to the local council. Returned CDs were brought to the attention of the RP, they were segregated in the CD cabinet prior to destruction and relevant details were entered into a CD returns register.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has an adequate range of equipment and facilities that it needs to provide its services. And, its equipment is used in a way that protects people's privacy.

Inspector's evidence

The dispensaries were appropriately equipped with the necessary equipment and facilities. This included a range of crown-stamped conical measures for liquid medicines, designated measures for methadone and counting triangles. Some of the latter however, could have been cleaner. The sinks in the dispensaries, used to reconstitute medicines were also stained and the one in the main dispensary should have been cleaner. There was hot and cold running water available as well as hand wash present.

Fridges were operating at appropriate temperatures for the storage of medicines and CD cabinets were present. The pharmacy was equipped with current versions of reference sources and staff had access to online resources. Computer terminals were positioned in a manner that prevented unauthorised access and the team used their own NHS smart cards to access electronic prescriptions which were taken home overnight.

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.