General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 The Parade, Silverdale Road, Earley, READING, Berkshire, RG6 7NZ

Pharmacy reference: 1028998

Type of pharmacy: Community

Date of inspection: 04/01/2024

Pharmacy context

This is a small community pharmacy in a residential area of Reading. The pharmacy provides a range of services including dispensing prescriptions. And supplying medicines in multi-compartment compliance packs for people living at home who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. And it provides a core range of other services, including a medicines delivery service and a Flu vaccination service.

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

The pharmacy has appropriate written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. And team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy risk assessed its services. And it provided non- essential services when the workload allowed and when it had enough suitably trained staff available to support the pharmacist. The pharmacy had systems in place for recording its mistakes. The responsible pharmacist (RP) described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. She did this to help prevent the same mistake from happening again. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it recognised that mistakes could occur between them. These included medicines such as such as amlodipine 10mg and amitriptyline 10mg. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. Since the company had changed to using an electronic system for recording near misses, the team had not been recording all its mistakes. While the team appreciated the benefits of capturing information electronically for head office review and analysis, it found that using the electronic system took longer. And it also meant that to record the mistake it often had to interrupt colleagues using the computers at the time. The records seen did not show what team members had learned or what they would do differently next time. So that they could prevent the same or a similar mistake.

The pharmacy used a barcode checking system to help reduce picking errors. And so, it did not make many. But the majority of those it did make involved the incorrect quantity. The RP reviewed the pharmacy's near miss records periodically. She agreed that if the team had more details of what it had learned from its mistakes, along with more frequent reviews, she could monitor them more effectively. She agreed that this would provide team members with a better opportunity to learn. And it would allow them to identify steps in their dispensing procedures which would help avoid mistakes in future. And any other follow up actions for ongoing improvement.

The pharmacy received regular bulletins from the company's professional standards team. The bulletins provided updates on current priorities for teams and educational information. And they also provided case studies to highlight the risks associated with high-risk medicines. A recent case study had covered the risks associated with the prescribing and supply of methotrexate. This was to raise teams' awareness of the risks of incorrect dosage instructions. It also made suggestions about how to manage the risk to ensure that people fully understood how they should take their medicine.

The pharmacy had a set of up-to-date standard operating procedures (SOP)s to follow. The SOPs were available on the Boots 'hub' application which team members had on their smart phones. Team members had read the SOPs relevant to their roles. And they had completed a quiz for each one to assess their knowledge and understanding. The pharmacy assistant (PA) serving customers on the

counter, was observed handling people's queries well. And her colleagues stepped in to support her when needed. She had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. She consulted the pharmacist and her other colleagues regularly when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. The PAs working as dispensing assistants, and the technician also consulted the RP when they needed her input. They accessed, used and updated the pharmacy's electronic records competently. And they were seen to work through their allocated tasks methodically. The RP had placed her RP notice on display showing her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint with head office if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time, or through the company's online portal. The RP commented that, the pharmacy had reviewed its systems for managing outstanding items owed to people. It had done this in response to incidents where team members had not been able to find people's 'Owings'. And there had also been confusion when people believed that the pharmacy still owed them an item which they had already received. As part of the review the team had reorganised its filing and retrieval systems and it had improved the process as a result. The pharmacy also tried to keep people's preferred brands of medicines in stock so that their medicines were available for them when they needed them. The pharmacy had professional indemnity and public liability arrangements so it could provide appropriate insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to. This included its private prescription records, records for emergency supplies and its RP record. The pharmacy kept its controlled drugs (CD) register properly. And it kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. The pharmacy also had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. They discarded confidential paper waste into separate waste bags. And a licensed waste contractor collected the bags regularly for safe destruction. The pharmacy kept people's personal information, including their prescription details, out of public view. And it had a safeguarding policy. Team members had completed safeguarding training. And they understood their safeguarding responsibilities. And they reported any concerns to social services or a person's GP as appropriate. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has put suitable measures in place to ensure it manages its workload safely and effectively. And its team members support one another. Team members are comfortable about providing feedback to one another so they can maintain the quality of the pharmacy's services. And they have the right skills and training for their roles.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP on duty was the regular RP. And she had worked at the pharmacy for approximately six months. Other team members present included the pharmacy technician, a foundation year trainee pharmacist and the two PAs. The PA role provided the team member with dispensing assistant training and medicines counter assistant training. And so, they could work wherever they were most needed, either in the dispensary or at the counter. The pharmacy was generally on top of its workload. It had closed for three days the previous week due to a leak which had caused some water damage and flooding. And the team had worked hard to catch up with the additional work this had caused. And they worked hard to keep on top of their dispensing tasks. At the same time, it dealt with people waiting for prescriptions or advice.

Staff described feeling supported in their work by their colleagues. And overall, they worked effectively with one another. The trainee pharmacist described having regular one-to-one meetings with the RP who was also his tutor. And he had protected training time every day. He and the rest of the team felt able to raise concerns with their line managers. Team members discussed issues as they worked. And they described how they had got together to review the way in which they managed the prescription workflow. They did this to ensure that they could get people's prescriptions ready for them more quickly when they came in to collect them. They also agreed to vary each team member's tasks, sharing them to provide variety and maintain interest and concentration. The RP made day-to-day professional decisions in the interest of people. And while she felt the pressures of a busy workload, she did not feel under pressure to meet any business targets. The team had not had any reviews about their work performance recently. But they discussed issues as they worked. And they kept their knowledge up to date through regular online e-learning training modules.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they provide an adequate amount of space for those services. The pharmacy is sufficiently clean and secure. The team keeps its workspace and storage areas appropriately tidy and organised.

Inspector's evidence

The pharmacy was on a small parade of shops and local businesses. It had a retail space with a consultation room and a small seating area for people waiting. And it had screens on top of its counter to help prevent the transfer of infections. The pharmacy displayed its pharmacy medicines on the backwall behind its medicines counter. The dispensary extended to the rear of the counter. It had an ‘L’ shaped area of work surface. And one part of this work surface allowed staff working there to oversee the retail space and the counter. And so, they could see when people needed attention. The other part of worksurface was more out of view. And staff could work here with fewer interruptions. This provided a slightly quieter area for team members to work.

The pharmacy generally had the workbench and storage space it needed for its workload. It had storage areas above and below its work benches. It also had a run of pull-out drawers and shelves for storing medicines and completed prescriptions for collection. The pharmacy stored its dispensed items and prescriptions so that it kept people’s information out of view. And it stored its medicines in a tidy, organised way. People could not view the pharmacy’s dispensing benches from the customer area. And this helped the team to keep people’s prescription information confidential. The team cleaned the pharmacy's work surfaces and contact points regularly. And in general, it kept the premises tidy and organised. Staff worked steadily to put stock away and store prescription orders appropriately. The consultation room was close to the dispensary. People outside the consultation room could not hear conversations taking place inside it. And the team locked it after use to prevent unauthorised access. The pharmacy had staff facilities, a small storeroom, and a fire door to the back.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that its services are supplied safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access and an automatic door. And the team kept the retail area relatively free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it also ordered some people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines together during dispensing to help avoid errors. It also had a barcoded prescription retrieval system. So, by scanning the code, staff could access the correct prescription efficiently. And they could also refer to the original prescription which remained attached.

Pharmacists gave people advice on a range of matters. And it experienced a relatively high number of referrals under the NHS CPCS scheme (Community Pharmacist Consultation Service). Over the Christmas period it had received a high number of referrals from local GPs and urgent care referrals from the NHS 111 service. Through the service it had helped people to receive appropriate treatment. And after making all the necessary checks, it provided them with essential medicines when they had run out. The RP explained how she gave advice to anyone taking higher-risk medicines. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This did not include people in the at-risk group. But the RP described the counselling she would give when supplying the medicine to ensure that at-risk people taking it were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets each time. And the RP was aware of recent changes around the packaging of each supply.

The pharmacy also offered a flu vaccination service. It had up to date PGDs and service specifications for both the private and NHS flu service. In general, the RP briefed the person receiving the vaccination appropriately, and asked for their consent. The RP followed appropriate hygiene procedures. And she discarded used vaccines safely into a sharps bin. The RP kept records of the consultation for each vaccination. This included details of the product administered. The pharmacy had procedures and equipment for managing an anaphylactic response to vaccinations.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was mostly tidy and organised. But it had stored the remains of a split pack of transdermal patches in a plain white dispensing carton. And the individual patches did not have a visible expiry date, batch number or patient information leaflet. And so, the patches could be missed if they were part of a medicines recall or a date check. The inspector discussed this with the RP, and they agreed that team members should

review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing. The team agreed that all medicines should be stored in the manufacturer's original packaging where possible.

The pharmacy date-checked its stocks regularly. And it kept records to help the team manage the process effectively. The team also conducted an expiry date check as part of its dispensing process. The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The pharmacy had several computer terminals which had been placed in the consultation room and the dispensary. Computers were password protected to prevent unauthorised access. And team members had their own smart cards to maintain an accurate audit trail when accessing people's records. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.