General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7-9 Station Road, BEACONSFIELD, Buckinghamshire, HP9 1NL

Pharmacy reference: 1029092

Type of pharmacy: Community

Date of inspection: 26/04/2019

Pharmacy context

This is a community pharmacy located on a main high street, near the train station in the centre of Beaconsfield in Buckinghamshire. A range of people use the pharmacy. The pharmacy dispenses NHS as well as private prescriptions. It offers a few services such as Medicines Use Reviews (MURs), the New Medicines Service (NMS) and a blood testing service for people prescribed warfarin. And, it supplies some people with their medicines inside multi-compartment compliance packs, if they find it difficult to take their medicines on time.

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 identifies and manages most risks effectively. The team record mistakes that occur during the dispensing process, they learn from these and act to prevent future mistakes occurring. Members of the pharmacy team understand how they can protect the welfare of vulnerable people. And, they protect people's private information well. The pharmacy generally keeps most records in accordance with the law. But, some of its records of private prescriptions were incorrect. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

A range of documented Standard Operating Procedures (SOPs) were present to cover the services provided. Roles and responsibilities of the team were defined within these. Staff declarations were complete to state that they had read SOPs. The team completed quarterly quizzes on SOPs to test and reinforce their understanding of processes. The pharmacy was very organised and clear of clutter.

The team attached the company's Patient Information Forms (PIFs) to all prescriptions so that relevant information could be easily identified. The Responsible Pharmacist (RP) accuracy checked prescriptions in one section of the dispensary. Staff explained that they checked and screened relevant details on prescriptions or medicines twice for accuracy before passing to the RP for the final check.

Near misses were routinely logged. Details were collectively reviewed every month by the pharmacist store manager. The company's Patient Safety Review (PSR) was used. The team were briefed about common mistakes every month. Issues with incorrect strengths were identified. This was being focussed on and to assist in raising the team's awareness, details were written onto PIFs and highlighted at the point of dispensing. There were also caution stickers placed in front of stock to identify some medicines as an additional visual alert. Quinine was kept separate to other medicines starting with a 'Q'. The team highlighted LASA's (look-alike and sound-alike medicines), by using caution stickers and PIFs.

Two members of staff were also patient safety champions. They worked through company workbooks, engaged the team on relevant points to ensure ongoing safety measures were reinforced, the team observed each other and provided feedback to help facilitate their learning. There was information on display in the retail area to inform people about the pharmacy's complaints procedure.

Incidents were handled by pharmacists. The procedure involved gathering relevant information, apologising, rectifying, documenting details on the company's system and investigating. If incorrect medication was taken, the prescriber was informed.

There was no confidential information left in areas that were accessible to the public. Sensitive details from bagged prescriptions awaiting collection were not visible from the front counter. Confidential waste was segregated into separate designated bins and disposed of through company procedures. Staff had completed the company information governance e-learning training and were trained on the EU General Data Protection Regulation (GDPR).

Staff could identify groups of people that required safeguarding and identify signs of concern. In the

event of a concern, the RP would be informed. They had read SOPs and completed training through e-learning. The procedure to follow with relevant and local contact details was readily accessible. Pharmacists were trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE).

The correct RP notice was on display. This provided details of the pharmacist in charge of operational activities. The RP record was mostly complete. There was one missing entry where the pharmacist had not recorded the time their responsibility ceased and the RP on the day of the inspection had signed out before her shift finished.

A sample of registers for controlled drugs (CDs), records of unlicensed medicines and emergency supplies were maintained in line with statutory requirements. Balances for CDs were checked and documented every week. Random spot checks of CDs held corresponded to balances stated in registers.

The minimum and maximum temperature of the fridge was routinely monitored to ensure medicines that required cold storage were appropriately stored. Records were maintained to verify this. The store manager completed checklists as part of the company's clinical governance processes. The company's pharmacy duty records were complete.

There was one missing entry of destruction within the CD returns register from 2018. There were incorrect prescriber details recorded for some entries within the electronic private prescription register and no prescriber details documented for one private prescription for a CD. Professional indemnity insurance arrangements for the provision of pharmacy services were in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members have an appropriate level of understanding about their roles and responsibilities. They are provided with resources to complete ongoing training. This helps to ensure that their skills and knowledge are kept up to date.

Inspector's evidence

The pharmacy dispensed 4,000 prescription items every month with 33 people receiving their medicines inside multi-compartment compliance packs and no people with instalment prescriptions.

There were two pharmacists and two pharmacy advisors present at the inspection, one of the pharmacists was a relief and company employed (the RP), the second was the store manager. One of the pharmacy advisors was trained and the other was undertaking accredited training appropriate for her role. There was also another trained pharmacy advisor and a part-time medicines counter assistant who was due to leave the business.

Staff wore name badges outlining their roles. Certificates to demonstrate qualifications obtained were not seen. Staff knew which activities were permissible in the absence of the RP. If the pharmacist failed to arrive first thing, the store remained closed. A range of questions were used by the team before selling medicines over the counter (OTC). They referred to the pharmacist when required. Staff held sufficient knowledge of OTC medicines.

Team members in training described completing course material at home and at work, as and when it was possible. The latter occurred regularly and when it was provided, the time was protected. Staff had access to e-learning modules, they read company newsletters and took instruction from pharmacists to keep their knowledge up to date. Details within the company's newsletters were routinely highlighted and the team were briefed by the store manager. Performance reviews for staff occurred quarterly and feedback was provided to them on their progress.

The relief RP stated that commercial targets set for her to achieve services were dependent on the store. There was an expectation to complete two MURs per day. This was described as manageable and there was no pressure applied to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the services it provides.

Inspector's evidence

The pharmacy consisted of a medium sized retail area and smaller, raised dispensary at the rear, on the left-hand side of the entrance. All areas were clean. Areas that faced the public were professional in appearance. The pharmacy was suitably lit and ventilated.

A consultation room was available for services and private conversations. This was situated along a corridor that led into the back sections. There was no sign in the retail space to indicate the presence of this room. This was discussed at the time. A curtain could be drawn across the door to enable privacy as the entrance was made of clear glass. The door was kept locked. The room was of a suitable size for services. Confidential information was stored inside a locked cabinet.

Pharmacy-only (P) medicines were stored behind the front pharmacy counter. Staff were always within the vicinity to prevent these medicines from being self-selected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable sources. It stores and manages these appropriately. The pharmacy provides its services safely and effectively. The team take extra care with people receiving higher risk medicines. This helps to ensure that people can take their medicines safely. But, team members don't always record relevant information when people receive these medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

There were automatic doors at the front of the store and entry occurred at street level. This coupled with the wide aisles and clear open spaces inside the pharmacy, enabled people with mobility issues to easily access the pharmacy. Three seats were available for people waiting for prescriptions. Staff described speaking clearly for people who were partially deaf and/or would take them to one side to maintain their privacy if needed. Medicines with braille were provided for people who were partially sighted. There were some leaflets on display and current documented details available in the pharmacy to signpost people to other local organisations.

PGD information for the services that the pharmacy provided were easily accessible and signed by authorised pharmacists. The anticoagulant monitoring service involved booking people for appointments, the store manager first checked relevant details such as bruises or signs of bleeding, then tested and monitored the International Normalised Ratio (INR) level. The SOP for the process was followed. Results and referrals were sent to the clinical lead as per the service's protocol. Specific dosing protocol or software was used to assist with dosage adjustments and to document details. The store manager explained that the service was convenient for people but it was due to stop in the near future.

Plastic tubs were used to hold prescriptions and items. This helped prevent their inadvertent transfer during the dispensing process. A dispensing audit trail from a facility on generated labels as well as a quad stamp assisted in identifying staff involved.

Prescriptions for people prescribed higher-risk medicines were identified using laminated cards. Staff routinely checked relevant information. This included asking about the dose, strength and blood test results such as the INR levels for people prescribed warfarin. Details were not routinely documented when people's records were checked. However, this did occur routinely for those people who were using the pharmacy's anticoagulation monitoring service.

Staff were aware of risks associated for people prescribed valproate who were in the at-risk group. Relevant material was present to provide to them upon supply. An audit had been completed and two people potentially at risk, were identified. The store manager explained that one person was already using a contraceptive and the second was aware of the risks. They were due to receive ongoing contraception.

Multi-compartment compliance packs were initiated after liaising with the person's GP and only if people were struggling to take their medicines on time. The pharmacy ordered prescriptions on behalf

of people. Staff cross-referenced details on prescriptions against individual records held for people. This helped them to identify changes and records were maintained to verify that this occurred. A communication book was also used to document relevant details. All medicines were de-blistered into packs with none supplied within their outer packaging. Packs were not left unsealed when assembled. Descriptions of medicines were provided. Patient Information Leaflets (PILs) were supplied routinely. People prescribed warfarin with packs were supplied this separately. Mid-cycle changes involved trays being retrieved, amended and re-checked before being re-supplied. Medicines were not delivered.

Licensed wholesalers such as Alliance Healthcare, AAH and Phoenix were used to obtain medicines and medical devices. Unlicensed medicines were received from Alliance Specials. Except for the store manager, staff were unaware about processes involved for the European Falsified Medicines Directive (FMD). There was no relevant equipment on site or guidance information present for the team.

Medicines were date-checked for expiry every week. A date checking schedule was in place to demonstrate that this had occurred. Staff used stickers to highlight short dated items. There were no date expired medicines or mixed batches seen. Liquid medicines when opened were annotated with the date of opening onto their packaging.

CDs were stored under safe custody. Keys to the cabinet were maintained in a manner that prevented unauthorised access during the day and overnight. A CD key log was completed as an audit trail to demonstrate this.

Assembled prescriptions awaiting collection were stored within an alphabetical retrieval system. Laminated cards were used to highlight relevant information such as CDs (Schedules 2 and 3), fridge and higher-risk medicines. Schedule 4 CDs were identified using stickers and PIFs. Clear bags were used to hold fridge and CD items once assembled. Uncollected prescriptions were checked and removed every five weeks.

Medicines brought back by the public that required disposal, were accepted by staff, stored in appropriate containers and collected in line with contractual arrangements. People bringing back sharps to be disposed of were referred to the local GP surgery. Returned CDs were brought to the attention of the RP and segregated in the CD cabinet before their destruction. Relevant details were entered into a CD returns register.

Drug alerts were received through the company system. Stock was checked and action taken as necessary. An audit trail was present to demonstrate the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy held current versions of reference sources and the team could access online reference sources. The CD cabinet conformed to legal requirements. Medicines were stored evenly within the fridge and at appropriate temperatures.

There were clean, crown stamped, conical measures available for liquid medicines. Counting triangles were present with a separate one for cytotoxic medicines. The sink in the dispensary used to reconstitute medicines was clean. Antibacterial hand wash and hot and cold running water was available.

Relevant equipment for the anticoagulant monitoring service was calibrated regularly with records present to verify. Portable Appliance Testing of equipment occurred twice a year. Computer terminals were positioned in a manner that prevented unauthorised access. Staff used their own NHS smart cards to access electronic prescriptions. The smart cards 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.