General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 Market Square, MARLOW, Buckinghamshire, SL7 3HH

Pharmacy reference: 1029145

Type of pharmacy: Community

Date of inspection: 10/10/2023

Pharmacy context

This is a community pharmacy located on the high street of a small affluent town in Buckinghamshire. The pharmacy dispenses NHS and private prescriptions. It offers some services such as seasonal flu vaccinations, the New Medicine Service, and local deliveries. And it supplies a few people with their medicines inside multi-compartment compliance packs if they find it difficult to take them.

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	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 largely has appropriate systems in place to identify and manage the risks associated with its services. The pharmacy maintains all its records, in accordance with the law and best practice. Team members understand their role in protecting the welfare of vulnerable people. And the pharmacy protects people's private information appropriately. Members of the pharmacy team deal with their mistakes responsibly. But they are not always recording all the details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future.

Inspector's evidence

The pharmacy was inspected due to a recent complaint made to the GPhC about the supply of an expired medicine. This had been handled appropriately by the store manager once it was brought to her attention and was found to be largely due to a lack of staff, being behind with the workload and behind with routine tasks such as routinely checking expiry dates of medicines (see Principle 2 and 4). The pharmacy team had access to a range of electronic standard operating procedures (SOPs). They provided guidance for the team to carry out tasks correctly and had been read by the staff. Team members understood their roles and responsibilities. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had systems in place to identify and manage risks associated with its services. Team members processed and assembled prescriptions in a different area to the responsible pharmacist (RP). The latter worked and accuracy-checked prescriptions from a separate section in the dispensary. Multi-compartment compliance packs were also assembled in a different room. Staff were observed working and focusing on one task at a time which helped reduce distractions. The dispensary was also clear of clutter on the day of the inspection. This helped minimise the risk of mistakes occurring. Incidents were managed by the pharmacist and store manager. The RP's process was suitable and in accordance with the company's policy. Staff had been recording their near miss mistakes although some gaps were seen within the comments section. The details recorded were reviewed every month, discussed amongst the team, and trends, patterns or issues identified.

The pharmacy's team members had been trained to protect people's confidential information and were aware of the need to safeguard vulnerable people. The trainee member of staff recognised a code word for people who required assistance due to domestic abuse. The RP had undertaken level two safeguarding training. Details about local safeguarding agencies were accessible. Confidential material was disposed of appropriately. Sensitive details on assembled prescriptions could not be seen from the retail space. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions.

Records of controlled drugs (CDs) were compliant with statutory and best practice requirements. This included the RP record, records of supplies made against private prescriptions and emergency supplies. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy were complete and the pharmacy had suitable professional indemnity insurance arrangements in place. Records verifying that the temperature of the fridge had remained within the required range, had also been maintained.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the pharmacy team have a range of skills and experience. They understand their roles and responsibilities well. The company provides its team members with resources so they can complete ongoing training. This keeps their skills and knowledge up to date. But the team requires more support. The pharmacy has limited staff and has been struggling to suitably manage its workload.

Inspector's evidence

Staff at the inspection consisted of a trainee dispensing assistant and a regular part-time pharmacist. In total the staffing profile consisted of another part-time pharmacist, a second trainee dispensing assistant and the store manager who was a qualified dispenser. Staff in training were enrolled on the appropriate accredited training but the trainee dispenser seen on the day had not been able to start this course. During the inspection, the inspector noted that the only trainee dispenser was required to serve people on the medicines counter and work in the dispensary alongside the pharmacist. This situation risked distractions and errors occurring. People were served promptly, but prescriptions were not ready to collect, Staff were preparing them when they arrived and giving appropriate waiting times. The pharmacy was currently around 10 days behind with the workload. At the time of the dispensing incident mentioned in Principle 1, the inspector was told that they had been six weeks behind, trained staff had left employment and they were very behind with routine tasks. This included date-checking of medicines.

The inspector was also informed by staff independently at a previous visit that team members were stressed and struggling. Whilst they had managed to catch up with some tasks, they were also still behind with certain routine tasks because of the staffing situation. Trainee dispensers also took time to gain the experience and knowledge required and needed their activities to be supervised. The store manager was spending all her time in the dispensary and was unable to fully complete managerial tasks required of her. Pharmacists were required to complete 25 vaccinations every day regardless of the pharmacy’s situation. Staff stated that there were usually queues down to the front door because they were normally busy with walk-in trade. The team also frequently suffered abuse from people using their services. In addition, staffing and the pharmacy’s hours had been cut. This included trading on Sundays.

However, a trained dispenser was due to re-start employment the following week. This would help alleviate some of the issues being experienced. Team members wore name badges and uniforms. They appeared to work well together, asked relevant questions before selling medicines and counselled people on the use of over-the-counter medicines. The trainee dispenser was aware of medicines which could be abused or had legal restrictions and sales of these medicines were monitored. Staff knew when to refer to the pharmacist appropriately. They were also provided with resources for ongoing training through the company’s e-learning platform and they read relevant updates. E-learning modules included mandatory training on health and safety, safeguarding and information governance. Discussions were said to take place regularly to keep the team informed and staff performance was managed by the store manager.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy premises provide an adequate environment for healthcare services. The pharmacy has a separate space where confidential conversations and services can take place. But some parts of the premises are untidy, cluttered and require updating.

Inspector's evidence

The pharmacy premises consisted of a spacious retail area but a very small dispensary and a small consultation room which was in front of the dispensary. There was limited bench space in the dispensary to safely prepare and assemble people's prescriptions. Another room was used to prepare compliance packs. This could be locked but had basic fittings, was quite cluttered at the time of the inspection and unprofessional in appearance. The dispensary was clean and tidy. The pharmacy was presented appropriately, suitably ventilated, and lit. However, the store as well as dispensary required refurbishing. Fixtures and fittings in the dispensary were old, showed signs of wear, and were ingrained with dirt due to age. The dispensary sink was stained. This was the same as the last inspection. Access to offices and staff facilities were restricted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services in a safe and effective way. Members of the pharmacy team identify people prescribed medicines which require ongoing monitoring, so that they can provide the appropriate advice. This helps ensure they take their medicines correctly. The pharmacy obtains its medicines from reputable suppliers and suitably provides people with their medicines inside multi-compartment compliance packs. But its team members are not routinely ensuring medicines are checked for expiry.

Inspector's evidence

People could enter the pharmacy from the street through wide, automatic front doors and sloped access. The area outside the pharmacy's retail area was made up of clear, open space which enabled people with wheelchairs or restricted mobility to access the pharmacy's services. A few seats were also available for people to wait if required. The pharmacy's opening hours were on display. Staff could make reasonable adjustments for people with different requirements. This included using representatives or other team members for people whose first language was not English. They also used written communication for people who were partially deaf, the consultation room was used when needed and they could print larger sized labels for people who were visually impaired.

The pharmacy provided local deliveries and the team kept records about this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended unless permission had been obtained beforehand. The pharmacy only supplied a few people's medicines inside compliance packs who lived in their own homes once a need had been identified for this. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. Compliance packs were not left unsealed overnight. All the medicines were de-blistered into the packs with none supplied within their outer packaging.

The workflow involved prescriptions being prepared by staff in one area before the RP checked medicines for accuracy from another section. The team used plastic tubs to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members also signed the quadrant stamp printed on the prescriptions forms to identify who was responsible for dispensing, accuracy checking, clinical checking and handing the prescription out. Staff routinely used these as an audit trail. During the accuracy-checking process, electronic pharmacist information forms (PIFs) were printed automatically when labelling and completed before being attached to prescriptions. This helped ensured that a clinical check of the prescription occurred and identified relevant points, such as services or changes to people's medicines. They also helped staff to counsel or advise people on how to take their medicine(s) appropriately.

Dispensed CDs and temperature-sensitive medicines were stored within clear bags. This helped to easily identify the contents upon hand-out. Staff used laminated cards to identify certain medicines or specific

situations. This included fridge lines, CDs, if pharmacist intervention was required, for paediatric prescriptions and for prescriptions with higher-risk medicines such as methotrexate, warfarin, and lithium. For higher-risk medicines, the cards also served as a reminder to prompt staff to ask relevant questions. For the latter, the team therefore routinely identified people prescribed medicines which required ongoing monitoring. They asked for details about relevant parameters, such as blood test results for people prescribed these medicines. Once verified, the pharmacy kept a record of the information obtained. Staff in training present at the inspection were aware of the risks associated with valproates. The pharmacist confirmed that people at risk had been identified previously and team members ensured the warning label was visible when this medicine was dispensed. Appropriate literature was available to provide to people at risk when supplying valproates.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were stored appropriately but they could have been kept in a more organised way. Team members confirmed that they were behind with ensuring medicines were date-checked for expiry regularly. Some sections of stock within the dispensary had been checked, others were still outstanding. This was due to the staffing situation. There were also gaps in the records to verify when this had happened. Short-dated medicines were not routinely identified but on randomly checking the stock, there were no date-expired medicines seen. Staff were advised to ensure additional accuracy-checks of the expiry dates took place when dispensing until they could catch up with this task. CDs were stored under safe custody. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This did not include sharps or needles which were re-directed accordingly. Drug alerts were received electronically, actioned appropriately and records kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has a suitable range of equipment and facilities available. Its equipment is sufficiently clean.

Inspector's evidence

The pharmacy had reference sources and relevant equipment. This included clean counting triangles, standardised, conical measures, a pharmacy fridge, a legally compliant CD cabinet and in general, a clean sink that was used to reconstitute medicines. The latter was somewhat stained. Hot and cold running water was available as well as hand wash. The pharmacy's computer terminals were positioned in a way and location that prevented unauthorised access. The team also used cordless phones which enabled private conversations to take place away from the retail space if 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.