

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2 Kingston Retail Park, Winchester Circle, MILTON KEYNES, Buckinghamshire, MK10 0BA

Pharmacy reference: 1029168

Type of pharmacy: Community

Date of inspection: 17/01/2020

Pharmacy context

This is a community pharmacy located on a retail park in Milton Keynes, Buckinghamshire. The pharmacy is open long hours. It dispenses NHS and private prescriptions. The pharmacy sells a range of over-the-counter (OTC) medicines and delivers medicines. It offers Medicines Use Reviews (MURs), the New Medicine Service (NMS) and seasonal flu vaccinations. And it supplies multi-compartment compliance packs to some people.

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 generally manages risks in a satisfactory manner. Members of the pharmacy team understand how to protect the welfare of vulnerable people. The pharmacy team members largely monitor the safety of their services by recording their mistakes and learning from them. But they don't always record enough detail. This makes it harder for them to spot patterns and help prevent the same things happening again.

Inspector's evidence

The pharmacy was relatively busy during the inspection. The workload was being managed appropriately during the inspection although there were only a few members of staff present (see Principle 2). The pharmacy was also cluttered initially until the store manager arrived to assist the team. The workflow involved one member of staff being based at one of the front counter units. They dispensed walk-in prescriptions here and dealt with the walk-in trade whilst another member of staff processed repeat prescriptions and managed the pharmacy's stock in the dispensary behind. Along with the responsible pharmacist (RP) both members of staff were also required to sell medicines and serve people on the medicines counter. This meant that staff were continually distracted and interrupted. They had also found more mistakes happening because of this (see below). Team members explained that they re-checked details when this happened and tried to serve one person at a time.

Laminated cards were used to highlight prescriptions for higher-risk medicines, controlled drugs (CDs), paediatric medicines and if pharmacist intervention was required. Staff attached pharmacist information forms (PIFs) to most prescriptions during assembly although some were seen in the retrieval system without this. Team members usually recorded their near misses although during the inspection, the near miss log was hidden under various bags and paperwork and there had been no entries made for the past few days. The near misses were reviewed every month and the company's Patient Safety Review was used to incorporate this information. However, there were gaps seen under the 'comments' section where details about the cause of near misses had routinely not been filled in. In addition, there were no details recorded about how the risks associated with staff being interrupted could be managed.

The company's practice leaflet was on display and this provided details about the pharmacy's complaints procedure. Pharmacists or the store manager handled incidents and their process was in line with the company's requirements. This included recording details on the pharmacy's internal reporting system, investigating the situation and identifying ways to minimise this happening again. Previous incidents had involved mistakes when handing-out prescriptions. Details were discussed with staff at the time and two further steps had subsequently been incorporated. Team members were required to match details on the prescriptions to bag labels when people arrived to collect their medicines, they signed the bag label and then proceeded to confirm the person's details including their postcode. The store manager was in the process of monitoring compliance with this and staff had been asked to watch a video on the company's internal system about this.

The pharmacy held a range of documented standard operating procedures (SOPs) to support services. They were dated from 2018 to 2019. The team had read and signed the SOPs, they understood their responsibilities and knew when to refer to the RP. Their roles and responsibilities were also defined

within the SOPs. The correct RP notice was on display and this provided details of the pharmacist in charge of operational activities on the day.

There was no confidential material left in areas that faced the public. Confidential waste was segregated and disposed of through the company's procedures. Sensitive details on bagged prescriptions awaiting collection could not be seen from the front counter. Team members had completed the company's information governance e-Learning training. Staff had been trained to safeguard the welfare of vulnerable people. They could identify signs of concern and referred to the RP in the first instance. The RP was trained to level two via the Centre for Pharmacy Postgraduate Education and local contact details for the safeguarding agencies were accessible.

The company's pharmacy log had been routinely completed. The team completed daily checks to ensure the fridges were operating at appropriate temperatures and records of the minimum and maximum temperatures had been maintained. Staff held a full audit trail of CDs that had been returned to them for destruction at the pharmacy and the pharmacy held appropriate professional indemnity insurance. The RP register was maintained in full although there were occasional crossed out or overwritten entries. Records of unlicensed medicines and a sample of registers seen for CDs were maintained in line with statutory requirements. The team checked and documented details of balances every week for the latter. Quantities of randomly selected CDs held in the cabinet corresponded to the balance stated in the registers. However, some records of emergency supplies were seen with no reason for the supply or the nature of the emergency being recorded, and some had incomplete information such as 'CPCS' or '111' only with no other details documented that could help justify the supply. In addition, occasional records of supplies made against private prescriptions were seen with prescriber details missing. So, the pharmacy may not have enough information available if problems or queries arise.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members understand their roles and responsibilities. They are suitably trained for their roles. And the company provides them with resources to keep their skills and knowledge up to date. Overall, the pharmacy has adequate numbers of staff to manage its workload. But it doesn't always have contingency arrangements to cover unplanned absence. And staff sometimes struggle to complete ongoing training at work. So, they may not benefit fully from the training resources available to them.

Inspector's evidence

At the time of the inspection, a relief pharmacist was present who had only worked at the pharmacy once before and two trained dispensing assistants, one of whom was part-time and the other full-time. The store manager arrived half-way into the inspection. She was also a trained dispensing assistant and stayed in the dispensary to help manage the workload whilst the inspector spoke to the rest of the team. Overall, the staffing situation was somewhat stretched during the inspection. The RP and two staff members were required to manage the dispensary and medicines counter. Some members of the team were off sick and there had been no contingency to cover them. The inspector was told that staff sometimes struggled to keep up to date with the workload. They were sometimes provided with assistance from the management team and one of the assistant managers was due to be enrolled onto accredited training as a pharmacy advisor. When asked about the staffing profile, the store manager said that the pharmacy had the required numbers of staff in line with its volume of workload.

Staff wore name badges outlining their roles. The team's certificates to demonstrate qualifications obtained were not seen. Staff were observed asking relevant questions before over-the-counter (OTC) medicines were sold, they provided advice and checked with the RP appropriately. To assist with training needs, the company provided staff with e-Learning modules, tutor packs, newsletters and updates. Some of the team stated that they completed e-Learning modules at home because it was impractical to do so at work and they could not always concentrate. The pharmacy's team members were described as not being fully up to date with their compliance and mandatory training for the current month. Staff appraisals were conducted every quarter to monitor their progress. They were a small team and details were discussed verbally with them. The relief RP described a target to complete two Medicines Use Reviews (MURs) a day which was said to be generally manageable.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide an appropriate environment for the delivery of healthcare services. The pharmacy is secure with a private area for conversations and services to take place.

Inspector's evidence

The pharmacy consisted of a spacious retail area and a small to medium-sized dispensary on the left-hand side of the entrance. The dispensary was made up of a front work bench which contained three units, one of which was enclosed to the public. The rest of the dispensary was also enclosed and there was enough space to carry out the pharmacy's dispensing activities safely. The pharmacy was clean. It was suitably bright, appropriately presented and well ventilated. Pharmacy (P) medicines were stored behind the front pharmacy counter and staff were generally within the vicinity to help prevent these medicines from being self-selected. A signposted consultation room was available for private conversations or services. The room was of an adequate size for its intended purpose. The door was kept closed but unlocked, there was no confidential information accessible and a curtain could be pulled across the door to maintain people's privacy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has extended opening hours and provides people with easy access to its services. The pharmacy's services are largely delivered in a safe manner. Team members routinely identify people receiving higher-risk medicines. They ask relevant questions and record this information. This helps to show that people are provided with the right advice to take their medicines safely. The pharmacy obtains its medicines from reputable sources. It stores and generally manages its medicines appropriately. But team members don't always provide medicines leaflets when they supply compliance aids. This means that people may not have all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy was open until midnight. After 8pm, the team provided services from a hatch. There were automatic doors at the front of the pharmacy and entry into the pharmacy was from the street. This, coupled with the wide aisles and clear, open space outside the pharmacy area in the store, enabled people with wheelchairs to easily enter and use the pharmacy's services. Staff could speak Romanian, Russian and Greek to assist people whose first language was not English. A hearing aid loop was available for people who were partially deaf, and staff knew how to use this. They verbally provided details for people who were visually impaired and checked their understanding. Two seats were available for people waiting for prescriptions. The pharmacy's opening hours were on display and there were plenty of car parking spaces available outside the premises.

Staff were aware of the risks associated with valproates. They described discussions being held with people at risk. A poster was on display in the dispensary to inform the team and the pharmacy held educational material to provide to people if prescriptions were seen. Prescriptions for people prescribed higher-risk medicines were routinely identified using laminated cards. Staff checked relevant information, such as asking about the dose, strength and blood test results. This included the International Normalised Ratio (INR) levels for people prescribed warfarin. This information had also been routinely recorded which helped verify this process.

The pharmacy provided a delivery service. It maintained audit trails to verify when and where medicines were delivered; this included highlighting CDs and fridge items as well as using separate sheets to record details about the former. The company's drivers obtained signatures from people 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 no medicines were left unattended.

The pharmacy usually supplied multi-compartment compliance packs after the pharmacist completed an assessment to determine people's suitability for this. The pharmacy ordered prescriptions on behalf of people and when received, details were cross-referenced against individual records to help identify any changes or missing items. Queries were checked with the prescriber and audit trails were maintained. Staff ensured that all medicines were de-blistered into the compliance packs with none left within their outer packaging. Descriptions of the medicines inside the compliance packs were routinely provided. Mid-cycle changes involved retrieving the old compliance packs and supplying new ones. However, the pharmacy team was not routinely supplying patient information leaflets (PILs).

During the dispensing process, plastic tubs were used to hold prescriptions and items. This helped prevent any inadvertent transfer taking place 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. Once dispensed, prescriptions awaiting collection were stored within an alphabetical retrieval system. The team used laminated cards to highlight relevant information such as CDs (Schedules 2 to 4), fridge and higher-risk medicines. Staff placed fridge and CD items into clear bags once they were assembled, this helped to identify them more easily when they were handed out. They checked uncollected prescriptions every week.

Licensed wholesalers such as Alliance Healthcare, AAH and Phoenix were used to obtain medicines and medical devices. Unlicensed medicines were received from Alliance Specials. Staff were unaware about the processes involved for the European Falsified Medicines Directive (FMD). There was no relevant equipment on site or guidance information present for the team and the pharmacy was not yet complying with FMD.

Medicines were stored in an organised manner and were date-checked for expiry every week; there was a date-checking schedule in place to verify that this had taken place. Staff used stickers to highlight short-dated medicines and there were no date-expired medicines or mixed batches seen. Liquid medicines were marked with the date upon which they were opened. CDs were stored under safe custody and the keys to the cabinet were maintained in a manner that prevented unauthorised access during the day as well as overnight. A CD key log was completed as an audit trail to verify this. Drug alerts were received through the company system, the team checked for affected stock and acted as necessary. However, the last documented audit trail seen was from June 2019. This limited the ability of the pharmacy to verify this process.

Medicines returned for disposal were accepted by staff and stored within designated containers. People requiring sharps to be disposed of, were referred to a 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 in a CD returns register. However, there were no designated bins to store hazardous or cytotoxic medicines and no list available for the team to identify these medicines.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities it needs to provide its services safely. Its equipment is clean and well maintained.

Inspector's evidence

The pharmacy was equipped with the facilities and equipment it needed to provide its services. This included current versions of reference sources, a range of clean, standardised conical measures for liquid medicines with designated ones for methadone and clean counting triangles. The dispensary sink used to reconstitute medicines was relatively clean. There was hot and cold running water available here. The CD cabinet was secured in line with statutory requirements and although the medical fridge was packed with stock, it was operating within the appropriate temperature range. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. There were cordless phones available to help with private or sensitive telephone conversations. Staff used their own NHS smart cards to access electronic prescriptions and took them 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.