

Registered pharmacy inspection report

Pharmacy Name: Boots, 100-102 Market Jew Street, PENZANCE,
Cornwall, TR18 2LE

Pharmacy reference: 1030091

Type of pharmacy: Community

Date of inspection: 23/07/2024

Pharmacy context

The pharmacy is in the centre of Penzance. It sells over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. The pharmacy offers a range of services including flu vaccinations, the NHS New Medicine Service (NMS), the NHS Hypertension Case Finding Service, the NHS Contraception Service and the Pharmacy First Service. It also offers a locally commissioned emergency supply service. The pharmacy provides medication and advice to drug users. The pharmacy also offers a delivery service. It dispenses medicines into multi-compartment compliance packs to help people remember to take their medicines. And the pharmacy dispenses medicines to the residents of 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

The pharmacy provides its services safely and effectively. It has adequate systems in place to identify and manage the risks associated with its services. The pharmacy team review and learn from any mistakes they make to improve the safety of the services they offer. The pharmacy team then work together to make changes to help to prevent mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. And these procedures are reviewed and updated regularly. The pharmacy asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's private information safe. Pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had appropriate processes in place to identify, manage and reduce its risks. It had standard operating procedures (SOPs) which reflected the way the team worked. Each team member had an online learning account which held a record of the SOPs that had been read. The SOPs were reviewed regularly by both the superintendent pharmacist and the pharmacy team. Each SOP had a short quiz at the end to test the understanding of the team member. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). Team members had clear lines of accountabilities and were clear on their job role. The pharmacy had risk assessments in place to cover its activities. And it had a written business continuity plan.

Pharmacy team members recorded any mistakes they made which were picked up during the final accuracy check, known as near misses, on an online reporting system. Dispensing errors that reached the patient were reported in a more detailed way using the same online reporting tool. Team members considered why the mistake had happened and learned from their mistakes. When errors occurred, the pharmacy team discussed them and made changes to prevent them from happening again. The nominated patient safety champion completed a detailed review of errors each month. They created an action plan which was shared with the team. Progress of the action plan was monitored frequently. The pharmacy had two separate dispensaries; one in the shop to serve members of the public and a second on the first floor which was used to dispense medicines into multi-compartment compliance packs and for the residents of care homes. The teams in each dispensary completed their own reviews of errors and created their own action plans. The key findings were shared between the teams to help them learn.

The pharmacy received regular training materials from the superintendent pharmacist's office which shared learning from incidents that had happened in other pharmacies. Members of the pharmacy team attended regular conference calls and meetings with other nearby branches of the chain where they discussed incidents and learnings as a group.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. There was information for people displayed in the retail area about how to provide the pharmacy with feedback. Any complaints were passed straight to the pharmacist or the manager to deal with. The manager made sure to pass any compliments received to the team. Public liability and professional indemnity insurance was in place.

The pharmacy kept a record of who had acted as the responsible pharmacist (RP) each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. Balance checks were completed regularly and any discrepancies were promptly rectified. A random balance check was accurate. Patient returned CDs were recorded in a separate register. The pharmacy kept records of private prescriptions on a register on the patient medication record (PMR) system and contained all legally required details. Records of any emergency supplies made using the locally commissioned service were appropriately recorded. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed.

All team members completed yearly training on information governance and general data protection regulations. Patient data and confidential waste were dealt with in a secure manner to protect privacy and no confidential information was visible from customer areas. A privacy policy and a fair data use statement were displayed in the retail area. Team members ensured that they used their own NHS smart cards. Verbal consent was obtained before summary care records were accessed and a record of access was made on the person's PMR.

All staff were trained to an appropriate level on safeguarding. The pharmacists and the pharmacy technicians had completed the Centre for Postgraduate Pharmacy Education (CPPE) safeguarding training to the appropriate level. All other members of the pharmacy team had completed appropriate training on safeguarding. Local contacts for the referral of concerns were available. Team members were aware of signs of concerns requiring escalation and knew what action to take.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members work effectively in their roles. They complete regular learning to update their skills and knowledge. All team members have completed, or are in the process of completing, appropriate training courses. The pharmacy team works well together by engaging in regular conversations to identify how improvements can be made in the pharmacy. And they understand how to raise concerns at work.

Inspector's evidence

The RP was an employed pharmacist who worked in the pharmacy regularly. On the day of the inspection, two pharmacy advisors were working in the dispensary in the main shop. A pharmacy technician and a pharmacy advisor were working in the second dispensary. There was also a second pharmacist working in the second dispensary, who had come to pharmacy to gain experience in the supply of medicines to care homes. A further two pharmacy advisors and a pharmacy technician were not working that day. Two team members were completing the in-house training programme and all other team members had completed an approved training course relevant to their role.

The pharmacy team were coping with the workload well and dispensing was up to date. The is was despite there being an NHS system outage in the previous days which had disrupted the transfer of prescriptions from GP practices. The pharmacy team felt well supported by the manager, the area manager and the company head office. It was clear that they worked well together and supported each other. They had regular 'huddles' to share information with each other. The team were encouraged to discuss concerns and give feedback to the manager and area manager, both of whom they found to be receptive to ideas and suggestions. The team felt able to make suggestions for change to improve efficiency and safety. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

Team members were observed giving appropriate advice to people in the pharmacy. And they referred to the RP for further clarification when needed. Team members knew what tasks could not be completed if the RP was not in the pharmacy.

Team members were given time during working hours to continue to develop and learn. They accessed a variety of different learning resources. Recent learning had included reading new SOPs and learning about new NHS services. The team encouraged each other to learn and helped each other. Each team member had regular appraisals where they could discuss their progress. The company was supportive of development opportunities.

The pharmacy team were set some performance targets. They found them manageable and they did not let targets affect their professional judgement. They ensured all services provided were appropriate for the person requesting them.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. The pharmacy has a consultation room where people can have private conversations with members of the pharmacy team. The pharmacy is adequately secured to prevent unauthorised access.

Inspector's evidence

The pharmacy occupied an area to the rear of the large store. There was a medicines counter a dispensary and a consultation room. A second pharmacy area was on the first floor, not accessible to the public, consisting of a large dispensary and several storage rooms.

The healthcare area of pharmacy was well-presented and clean. The healthcare counter was clear of clutter and there were health-related leaflets on display. There were seats available for people to use while they waited. The dispensary was an adequate size and well organised. There was plenty of work bench space and shelving. Most stock was stored neatly in a bespoke drawer unit. Larger items of stock were stored on shelves. The fixtures and fittings were well maintained. The pharmacy had a consultation room that was clearly advertised. It was large enough to accommodate several people and would easily fit wheelchairs and prams. People could not hear conversations from outside. It was locked when not in use and no medicines or personal information were stored in the room. Prescriptions awaiting collection were stored using a retrieval system and confidential information was not visible to waiting customers. Lighting was appropriate and the temperature was satisfactory for the provision of healthcare and the storage of medicines.

The dispensary on the first floor was large and well-equipped. There was plenty of storage and bench space. Minimal stock was stored in the room as items were ordered as needed.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy supplied medicines to people safely. And it ensures it gives appropriate advice to people to make sure they use medicines correctly. The pharmacy team make sure that people with different needs can access its various services. Team members take steps to identify people prescribed high-risk medicines to ensure that they are given additional information and that the medication is supplied and taken safely. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes regular checks to ensure that they are still suitable for supply. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy had step-free access and was wheelchair accessible. It had an automatic door. Plentiful parking was available nearby. The pharmacy provided additional support for people with disabilities, such as producing large print labels. A range of health-related posters and leaflets were displayed. Team members explained that if a person requested a service not offered by the pharmacy at the time, they referred them to other nearby pharmacies or providers, calling ahead to ensure the service could be provided there. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear flow to ensure prescriptions were dispensed safely. Team members used baskets to store dispensed prescriptions and medicines to prevent transfer between patients as well as to organise the workload. The pharmacy used an automated dispensing system to dispense a proportion of its prescriptions where medicines were dispensed and checked electronically. Safeguards in the system mean that any incorrectly scanned medicines were rejected and the prescription could not be completed until the correct medicine was scanned.

Coloured alert cards were used to highlight prescriptions containing high-risk medicines, fridge items and CDs in schedules 2 and 3. And a new system had recently launched where alerts flashed up on the computer when these medicines were handed out. This helped to ensure team members gave appropriate advice to people collecting them. The pharmacist had conversations with people receiving high-risk medicines to ensure they had had blood tests recently and give additional advice as needed. The RP said that they routinely spoke to the parent or guardian or children receiving medicines to ensure they knew the correct dose and to give additional information.

Multi-compartment compliance aids were supplied by the pharmacy for people living in their own homes. The compliance packs were mostly prepared by a robotic dispenser at a nearby hub and delivered back to the pharmacy. Each person requesting compliance aids was assessed for suitability. The workload was organised and well planned. A sample of compliance aids was inspected. Each compliance aid was clearly labelled and contained a description of the tablets included so that they could be easily identified. Patient information leaflets (PILs) were supplied each month. 'When required' medicines were dispensed in boxes and team members were aware of what could and could not be placed in trays. A record of any changes made was kept on a patient information sheet, which was available for the pharmacist during the clinical checking process.

The pharmacy dispensed medicines for the residents of care homes. They were supplied in original

packs rather than multi-compartment compliance aids. A medicines administration record (MAR) sheet was supplied for each person to allow the care home staff to record administration of medicines. Medicines were delivered approximately one week before the start date. Any medicines that were urgently required were usually delivered on the same day. The pharmacy also kept stocks of medicines used in palliative care so that they could be supplied promptly.

The pharmacy offered a range of additional services including flu vaccinations. The pharmacist had completed the required training to administer vaccinations safely. The pharmacy supplied opioid replacement medicines to people, some of whom were supervised taking their medication. The RP liaised with the drug and alcohol team and the person's key worker in the event of any concerns or issues. The pharmacy offered the NHS New Medicines Service. The RP contacted people prescribed new medicines to check how they were getting on and to offer any advice needed. The pharmacy was actively providing the new NHS Pharmacy First service. The team had supportive information available to support the safe delivery of this service, including current versions of the national patient group directions. And there were checklists available to support team members in triaging people attending for the service.

The pharmacy delivered medicines to people's homes using employed drivers. The drivers made a record of each delivery using an online system. If people were not home, the medicines were returned to the pharmacy and team members contacted the person to rearrange delivery.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate and topiramate and the need for a Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. They were aware of the new requirement to only dispense valproate in original packs to ensure people receiving it could see the warning about the risks of becoming pregnant whilst taking it. The RP had regular conversations with the people at risk who were prescribed valproate to ensure they were on adequate contraception.

The dispensary stock was arranged alphabetically on a bespoke shelving unit. It was well organised. Date checking was undertaken regularly and records were kept. Spot checks revealed no date-expired medicines or mixed batches. Prescriptions containing omissions were appropriately managed and the prescription was kept with the balance until it was collected. Stock was obtained from reputable sources. Records of recalls and alerts were actioned promptly. Relevant alerts were printed and stored with any quarantined stock.

CDs were stored in accordance with legal requirements in approved cabinets. A denaturing kit was available so that any CDs awaiting destruction could be processed. Date-expired and patient-returned CDs were clearly marked and segregated in the cabinet. The pharmacy had a separate register for patient-returned CDs and destroyed them promptly in the presence of a witness. The dispensary fridges were clean, tidy and well organised and records of temperatures were maintained. The maximum and minimum temperatures were within the required range.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services. It keeps these clean, tidy and well-maintained. The pharmacy uses its equipment in a way that protects people's confidential information.

Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Team members had access to the internet to support them in obtaining current information. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised view.

The pharmacy had clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher-risk medicines. This helped to reduce any risk of cross contamination.

A range of consumables and equipment to support the services provided by the pharmacy was available within the consultation room. Electrical equipment was visibly free of wear and tear and in good working order. The sinks and fridges in the dispensary were clean and well-maintained.

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.