General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 51 High Street, BRENTWOOD, Essex, CM14 4RH

Pharmacy reference: 1030963

Type of pharmacy: Community

Date of inspection: 16/05/2023

Pharmacy context

This pharmacy is situated in the town centre in a parade of shops. As well as dispensing NHS prescriptions the pharmacy provides seasonal flu vaccination and private services including travel vaccinations. It also provides the New Medicine Service and the Community Pharmacist Consultation Service.

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

Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. The pharmacy identifies and manages the risks associated with its services to help provide them safely. The pharmacy regularly seeks feedback from people who use the pharmacy. Team members make records of mistakes. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

Standard operating procedures (SOPs) were available electronically and were up to date. Team members were required to read SOPs via their individual training profile. Hard copies of SOPs were also available. All team members had completed the SOP training required for their roles. The store manager was able to see the overall training team members had completed as well as tracking progress.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were brought to the attention of the team member who had dispensed the medication and the mistake was recorded by the responsible pharmacist (RP). The RP explained that she planned to train team members to record their own mistakes. Each month a patient safety review was completed by the assistant manager after which the team were briefed on the findings and next steps. Recent reviews had identified that incorrect quantities were the most common mistakes and this was happening as split packs were not being fully marked. All team members had been briefed on ensuring all sides of a split box was marked and to write and circle the quantity when using a blank box. In the past different strengths of some medicines had been separated on the shelves. The RP said the computer system was good in identifying mistakes when someone had picked the wrong medicines. The regular pharmacist had been off work for some time and had found that the team were not consistently recording near misses, this had been identified as part of the patient safety review. And the team had been briefed to ensure all mistakes were being recorded. Dispensing errors were reported online. The RP described the process that would be followed in the event that there was a dispensing error and explained that the new computer system had reduced the number of errors.

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was available, and the pharmacist tried to resolve any complaints in store where possible and the person was referred to the right person in the team who could help them. A patient guide and complaints form were given to everyone for all the private services provided. As a result of feedback in the last two weeks the pharmacy team had put up signs to explain that there was only one queue for the pharmacy and medicines counter. The RP said this had worked really well in helping with queue management.

Records for private prescriptions, emergency supplies, unlicensed medicines, RP records and controlled drug (CD) registers were well maintained. CDs that people had returned were recorded in a register as they were received. CD balance checks were completed at regular intervals.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in a way to ensure people's private information was out of sight of the public. Team members all completed mandatory annual refresher training about information governance. Team members who needed to access NHS systems had individual smartcards; the trainees had applied to obtain their smartcards. Pharmacists had access to Summary Care Records and consent to access these was gained from people verbally. Confidential waste was separated into designated bags and sent to head office for destruction.

Pharmacists had completed level two safeguarding training and other team members had completed the Boots mandatory training about safeguarding, electronically. Contact details were available for local safeguarding boards and the team knew that these were also available online. The team had in the past raised concerns when they had been concerned about an individual.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members do the right training for their roles and the services they provide. And they work together well to manage the workload. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the RP who was the regular store-based pharmacist, a second pharmacist was also present to support the RP as she was due to go on long term leave. There were two trainee dispensers and a trainee pharmacist. All team members had completed or were in the process of completing an integrated training course which allowed them to work on the medicines counter and in the dispensary. Other team members who were not present during the inspection were a trained dispenser and a trainee dispenser. All four managers who worked at the store were trained to work on the pharmacy counter and the dispensary along with a team member who worked in the beauty department and would help when needed. The RP felt that there were enough staff for the services provided and the team was up to date with its workload. The pharmacy had just recruited a trainee dispenser.

A team member was observed to counsel people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was seen to refer to the pharmacist when she was unsure. She was aware of the maximum quantities of medicines that could be sold. To keep up to date, team members completed ongoing training. Team members also completed training on the e-learning platform. Digital records were kept and progress on completion was monitored by the store manager. E-learning modules included mandatory training on health and safety, safeguarding and information governance. Information resources were also provided which had details of product of the week, counterintelligence documents, and representatives came in from different manufacturers. Team members described they had recently received some training about Allevia from a representative. Team members were provided with time to complete training in store but this depended on the workload. Team members asked pharmacists or the trainee pharmacist for help. Team members who were completed formal training courses had an assigned tutor who ensured that the trainee had time to complete their training but also made time to ensure that they could go over the training material and help with any queries.

The trainee pharmacist said she was supported really well by her tutor. She was enrolled on the Boots learning programme and was provided with set-aside training time. She had worked on the medicines counter for the first two months when she had started and then moved to the dispensary. The trainee had met all the learning outcomes and was asked to complete mock checking which helped identify any weaknesses. Locum pharmacists were advised of the activities the trainee was allowed to complete by the supervisor and the trainee checked with them if they were happy to allow this.

The pharmacy team received a monthly Professional Standards bulletin from the superintendent's office. This also covered learning from errors and included case studies. Team members were all required to read thorough this and sign once they had done so.

The format for managing staff performance had changed and it was based more on 'in the moment

feedback.' Team members were supported with their training. If someone was not performing the store manager would have a sit down with them. Team members felt able to make suggestions and give feedback and there was a process in place for escalating issues. The team discussed things as they came up. Any updates or information was relayed to the team in the morning. Meetings were held if there was specific information to share. The team had get-togethers out of hours to celebrate success. The RP thought there were targets but she was not informed of these by the store manager as she said the pharmacy provided services consistently when there was a need for them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean; the dispensary was large with large with ample workspace which was clear and tidy and was allocated for certain tasks. There were designated areas for storing prescriptions waiting for stock or an accuracy check. A clean sink was also available in the dispensary. Cleaning was carried out by a cleaner who came in daily and also by the team members. Medicines were arranged on shelves and pull-out drawers in a tidy and organised manner. The room temperature and lighting were adequate for the provision of healthcare. The store temperature was regulated. Air conditioning was available. The premises were kept secure from unauthorised access. The pharmacy was open shorter hours then the rest of the store and was kept secure from unauthorised access.

A clean, signposted consultation room was available. The room allowed for conversations to be held inside which would not be overheard. The room was locked when not in use. Some paperwork was held the room. The RP said that people were not left unattended in the room

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible for people. And it manages its services well, so that they are provided safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy was easily accessible from the street with a flat entrance and automated doors. There was easy access to the medicines counter which had a lowered counter on one of the sides. A hearing loop was also available, and the pharmacy had the ability to produce large print labels. Services provided within the store were advertised and some team members were multilingual or used translation applications on mobile phones. People were signposted to other services were appropriate. Team members had knowledge of the local area and had good working relationships with other local pharmacies. There was a Boots opticians and hearing care centre across the road that the pharmacy worked closely with.

The RP felt the flu vaccination service had the most impact, especially where the surgeries where the flu vaccination sessions were only open for two days a week and people were able to book appointments. People preferred being able to book appointments at the pharmacy and come in when it was convenient for them. People had also provided feedback that they preferred the one-to-one service provided.

Most prescriptions were received electronically by the pharmacy. Team members checked stock availability when people walked in to have their prescriptions dispensed and depending on availability these were dispensed away from the front counter by one of the dispensers and handed to the RP for a check. Prescriptions for antibiotics and acute medicines and medicines for palliative care were processed and dispensed straight away, and people were sent a message once their prescription was ready. Other prescriptions were entered onto the system and stock was ordered. Once the stock was received the labels were printed and medicines dispensed. The labelling system required barcodes from the medicine packs to be scanned in order for the label to be generated. Dispensing audit trails were maintained. Team members signed the quadrant stamps printed on the prescriptions forms to identify who was responsible for dispensing, accuracy checking, clinical checking and handing the prescription out. Dispensed and checked by boxes were also available on the labels which were used by all team members. Plastic tubs were used to separate prescriptions to prevent transfer between patients. The pharmacists did not have to self-check including at weekends.

Pharmacist Information Forms (PIFs) were used to flag services suitable for the person and to highlight any clinical issues or changes to the prescriptions. These were printed automatically when labelling. PIF forms showed if there was a CD on the prescription, the expiry date for the prescription if a CD was present, if there were any fridge lines, any changes from previous doses, new medications. Any additional information was recorded on the PIF by the dispenser. Team members used laminate cards to highlight prescriptions for CDs, fridge lines, and for medicines such as methotrexate, lithium and warfarin. These cards had question prompts at the back for information to check with the patient.

Other laminates were available for 'refer to pharmacist' and paediatric prescriptions.

The pharmacy had recently completed an audit for sodium valproate. As part of this they had found that they did not have anyone who fell in the at-risk group. All team members had read the SOP for dispensing valproate. The team were aware of the warnings and the labelling requirements and described that the system did not allow them to split packs. The RP was aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). She would check previous history and people in the at-risk group who were not part of a PPP would be referred to their prescriber. Any communication with prescribers would be recorded. Team members checked at the point of handout with the person if the correct insulin had been supplied. Laminates were used for medicines such as methotrexate and warfarin which had reminders of checks that needed to be completed. People were requested to bring in their yellow book when collecting warfarin which was checked, and details recorded on the person's electronic record.

A small number of medicines were supplied in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people for this service. People who used the service collected packs on a weekly basis and prescriptions were usually ordered when the last pack was handed out. Individual record sheets were available for each person. Any changes or missing items were queried with the surgery and recorded on the sheets and the RP was informed. Emergency numbers were also recorded on these sheets. Packs were prepared by a dispenser. People signed a record each time they collected a pack. Assembled packs seen were labelled with product descriptions and mandatory warnings. Information leaflets were supplied monthly. Individual people's records and medicines were stored in allocated baskets.

Signed and in date patient group directions (PGDs) were available for the services provided. Pharmacists were required to complete online training as part of the accreditation and had face-to-face training for the vaccination training which included anaphylaxis.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. CDs were kept securely. Date checking was done routinely with a section checked each week. No date-expired medicines were seen on the shelves checked. A date-checking matrix was available. Short-dated stock was labelled, and a record was also made. Short-dated stock was removed at the end of each month. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors. Drug recalls were received electronically from head office on the computer system, the system was updated two to three times a day. The pharmacy team had specific allocated times for checking for alerts through the course of the day. Once they were actioned team members were required to update the system. Alerts were also printed and filed in the dispensary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely and maintains it appropriately. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had glass, crown-stamped measures, and tablet counting equipment. Separate labelled measures were used for liquid CDs to avoid cross-contamination. Equipment was clean and ready for use. The pharmacy had two medical grade fridges and a legally compliant CD cabinet. Up-to-date reference sources were available including access to the internet. Computers were all password protected, with all team members having individual passwords and screens faced away from people using the pharmacy.

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.