General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 64-66 High Street, BILLERICAY, Essex, CM12 9BS

Pharmacy reference: 1030973

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

This is a community pharmacy located in a parade of shops on a busy high street. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also provides flu vaccinations and supplies medicines as part of the Boots online medicines service. The pharmacy also acted a collection point for owings dispensed at the Boots pharmacy in Basildon hospital.

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	2.2	Good practice	Team members get time set aside for training, training is monitored through regular conversations and any gaps in knowledge are identified.
3. Premises	Standards met	3.1	Good practice	The pharmacy proactively makes changes to the premises to be able to provide the services more safely.
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's working practices are generally safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. They are good at recording and learning from any mistakes. This helps them make the pharmacy's services safer.

Inspector's evidence

Standard Operating Procedures (SOPs) were up to date. Members of the team had read SOPs relevant to their roles and were in the process of reading updated SOPs which covered the dispensing process and the multi-compartment compliance pack service. Team roles were defined within the SOPs.

In the event that a near miss was identified the responsible pharmacist (RP) asked the team member to have another look at what they had dispensed, identify the error independently and make an entry on the near miss log. The RP also had a chat with the team member to see how the error could have occurred. A review of all near misses and dispensing incidents was normally carried out once a month as part of the Patient Safety review to identify any patterns. As part of this review the RP also checked to see if individual team members needed additional support. Following the Patient Safety review carried out in March, it had been highlighted that there had been issues with handing prescriptions out. As part of this the RP had observed team members handing prescriptions out to check if they were following the procedure set out in the SOPs. The pharmacy had not completed a patient safety review since March. The team said that this was as they had been very busy with the launch of the new electronic patient record system, Columbus. Each month the team also read and signed the Professional Standards bulletin which was sent by the superintendent and also covered learning from errors. Following a near miss the team had moved quinine and quetiapine on the shelves.

Team members said that when medicines which looked alike or sounded alike (LASA) were dispensed, dispensers read the product name aloud when picking stock. Head office had identified a list of LASA medicines and lists were stuck on each workstation to prompt the team. The team had also attached 'handle with care' labels near areas where they had identified that the team made errors.

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. As a result of an incident were Movicol plain had been supplied instead of the paediatric Movicol plain, the team had moved all paediatric preparations to a different shelf so that both types were completely separate.

The pharmacy had a complaints procedure in place and details of the customer care team were printed at the back of the receipts. Annual patient satisfaction surveys were also carried out. The team also handed out patient survey cards which could be completed online at any time with feedback sent to head office. The practice leaflet also had information on how people could raise matters further. In-store complaints were handled by the RP or store manager who would try and resolve them. If a complaint was made centrally this was cascaded to the store via the area manager and investigated. The RP said that as a result of feedback an extra chair with arms had been added to the waiting area.

The correct responsible pharmacist (RP) notice was displayed. 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.

Records for unlicensed specials, RP records and controlled drug (CD) registers were well maintained. Records for private prescriptions were generally well maintained but some of the entries observed did not have the correct prescriber details or the correct date on which the prescription had been issued. Emergency supply records would be made electronically; the team had not made any supplies since moving to the new system.

CD balance checks were carried out on a weekly basis. A random check of CD medicines complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored on a retrieval system and were not visible to people. An information governance policy was in place and each year the team were required to complete training on the e-Learning system. The team had also completed an e-learning module on the General Data Protection Regulation (GDPR). Except for two members, the team had individual smartcards and passwords to access the NHS electronic systems. The RP said he was in the process for arranging smartcards for the two members who did not have one. The RP had access to Summary Care Records and consent was gained verbally, he said if the person had an electronic patient medication record he would annotate this on there.

The team had completed safeguarding training on the e-learning system; in addition to this the RP had also completed the level 2 training. Details for the local safeguarding boards were available in the safeguarding toolkit. The RP said that delivery drivers were managed by a central team and had also completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

On an average shift the team comprised of the RP plus an additional three to four trained team members (mix of counter assistants and dispensers). The store manager was also a trained dispenser and supported the team when needed. He explained that the pharmacy team members were interchangeable, so the dispensary team would help cover the medicines counter. The pharmacy had dedicated counter staff two days a week and at the weekend.

The store manager said that the store had the full number of staff that he was allocated. The pharmacy had switched to Columbus, a new operating system the previous week and as the stock record had been out of sync the pharmacy had received a large volume of excess stock. The RP said that prescriptions were triaged as they were received. Antibiotics and pain relief was dispensed as a priority as people were more likely to present to collect these. The pharmacy was up to date with dispensing.

Staff performance was managed by the store manager who held informal quarterly reviews with all team members. He checked to see how team members were doing asking the RP for feedback. An annual formal review was also completed. The store manager said that this year Boots had taken away the link to the bonus and introduced a five-tier marking system. Performance improvement plans were used where needed. The store manager said that he tried to manage performance by having a 'learning conversation' with the team member and letting them know what the expectations were. If someone had any gaps in their knowledge the Pharmacy operations & governance manager (POGM) was good with signposting the store manager to sources of information that could be used such as specific e-learning modules. Team members had time set aside for ongoing structured training.

The pharmacy advisor counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of some medicines that could be sold over the counter. She described handing out prescriptions in line with SOPs and was aware that pregabalin was a CD.

The team were provided with regular training modules on e-learning which covered a range of different topics and areas. The latest training completed had been on Columbus. In addition to this team members also completed quarterly health and safety modules. The team members could take time in store to complete their training. New training was flagged to store managers at the area meeting or on the area conference call. The store manager passed on relevant information to the team. He said that as team members worked in both retail and pharmacy they needed to know about everything. The team had given feedback to other stores on how Columbus worked as they were one of two stores that had gone live.

The team had a meeting following the monthly patient safety review. The RP said he preferred discussing near misses as they occurred, the store manager updated the team on performance each

week. He worked across all days so was able to catch up with all the team members. The RP worked on one Sunday each month and caught up with Sunday staff then.

Team members said that they were able to give feedback and suggestions. The RP and store manager talked the team through any new changes such as the new system. Team members shared what they knew with colleagues to make sure that everyone could use the system.

'Let's Connect' events were attended by the pharmacists and the store manager so that they could share learning with teams in other stores. The event covered key updates in pharmacy, company focuses and provided an opportunity to complete CPD.

As well as receiving the monthly Professional Standards bulletins the team received alerts on Boots live (the company intranet). This could be accessed by the store manager, RP and another team member. Boots Live was used to communicate tasks, alerts, and gave dates by when things needed to be done and who needed to do it. The company had taken on feedback from stores and reduced the amount of information being sent through via Boots Live. And the new Columbus system was designed by dispensers and pharmacists. The team discussed things as they came up.

Targets were in place for services offered. The pharmacy had a service budget which included MUR, NMS and flu jabs. The RP said that he was aware that there was a business need for the targets but he said that they would not affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are largely clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was bright and in the main clean. It was suitable for the provision of healthcare. There was some rubbish around the dustbin in the dispensary which was picked up during the course of the inspection. Workbench space was allocated for specific tasks. Multi-compartment compliance packs were prepared in a dedicated room. The store manager said that he had requested for this to be built so that the packs could be prepared away from distractions in the main dispensary and to have an allocated area where charts, trackers and records related to the provision of the service could be kept. This also ensured that there was more space available in the main dispensary to continue with other dispensing services. Cleaning was done by the team with a rota in place and a contracted cleaner also came in. Medicines were arranged neatly. A clean sink was available.

There was a clearly signposted consultation room available for people to have private conversations. People could have conversations inside which would not be overheard. The consultation room was clean and tidy. A curtain was used to cover the glass door if additional privacy was required. Information containing people's personal details was stored in a lockable filing cabinet. There was a sink and hand washing facilities available. A small fridge had been moved into the room to create space in the dispensary. The fridge was empty at the time of the inspection. The RP said the fridge was not being used and for this reason the temperatures were not monitored.

The premises were kept secure from unauthorised access.The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to regulate the temperature, this was controlled centrally.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful and they make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street with wide step-free entrance and power assisted doors. There was easy access to the medicines counter and there was a lowered counter for people using mobility aids. The pharmacy had the facilities to print large print labels. And it had a hearing loop. All team members had completed disability discrimination training.
Team members were aware of the need to sign post people to other providers if a service was not available at the pharmacy and said that they would use the internet if they were not familiar with a particular service.

The RP felt that the New Medicines Service (NMS) and Medicines Use Reviews (MUR) had an impact on the local population as it offered people reassurance that they were taking their medicines correctly. And he said that he was able to impart useful advice such advising people to rinse their mouth after using steroid inhalers like Fostair. The RP said that compliance packs also made a difference as there was a large elderly population locally and some people had carers. A number of care agencies insisted on medicines being supplied in compliance packs so that their carers could administer them. The RP said that request for people to have their medicines supplied in compliance packs usually came from the family and the team would have a conversation with the person's GP first. On one occasion the RP had picked up during the MUR that the person was very confused and could not remember to take all his tablets. Following a conversation with the GP the person was switched to the compliance pack service which had made a big difference.

The pharmacy had also had a large uptake of the flu vaccinations and provided almost 700 vaccinations. The RP said that due to stock issues people had come from surgeries based further away. The pharmacy had worked together with another pharmacy across the road, swapping stock to ensure that people could be vaccinated.

The pharmacy's workflow had recently changed due to the introduction of the new system, Columbus. Prescriptions were dispensed and triaged. These were then split into two piles depending on if they had been ordered by the pharmacy or the person directly. Then the data from the prescription was entered onto the system which ordered the stock. When the stock was received it was laid out and then using the prescription was picked for each person. The barcode on the pack was then scanned which generated a label. Team members said that a label was only generated if the correct item had been picked. Pharmacist Information Forms (PIFs) were filled out at the point of data entry. This had information relating to allergies, interactions, eligibility for services or any other information the team member wished to relay. Warning laminates were also placed with high-risk drugs and those where pharmacist intervention was required. Laminates for high-risk medicines had question prompts at the back which reminded the team member on what to ask people when handing out their prescriptions. Prescriptions were checked by the pharmacist once they had been dispensed.

A quad stamp was used which was initialled by all members of the team to create an audit trail for each stage of the dispensing and supply processes. Since the new system was installed a fifth box was introduced to be initialled by the person who had completed the data entry. Dispensed and checked by boxes on labels were also initialled by members of the team. The pharmacy team used tubs to ensure that people's prescriptions were separated.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The pharmacy did not have anyone who regularly collected sodium valproate who fell in the at-risk group.

When dispensing other high-risk medications, the RP and dispenser said that the warning cards were used. For warfarin prescriptions the RP checked the yellow book looking at the date of the last blood test and the targeted INR which was recorded on the patient medication record (PMR) for people who were regularly taking warfarin. The RP was observed to check this information over the telephone with a person who had their medicines delivered. A nearby pharmacy offered warfarin under a patient group direction, and most people were supplied their warfarin from there.

The pharmacy dispensed prescriptions as part of an online medicines service. There was a list of conditions that people could obtain treatment for. People were required to complete a questionnaire on the website after which a private prescription was issued and sent to the pharmacy via an online portal. The person was notified and would then come in and collect their medicines.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Individual record sheets were in place for each person. Prescriptions were usually ordered a week in advance. Prescriptions were checked against the individual record and any missing items or changes were chased up and confirmed with a note made on the individual record. Prescriptions were labelled and stock was collected after it had been clinically checked. Packs were then prepared and sealed after which they were checked by the RP. If someone was admitted into hospital, the team were made aware by either the hospital or the person's representative. People were supplied with two weeks' worth of medicines on discharge. The team asked the patients representative to bring in discharge summaries. The dispenser said that the way in which the service was managed could potentially change with the introduction of Columbus.

Assembled packs observed were labelled with product descriptions, mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly.

Deliveries were carried out by drivers who were based at a hub. People were called prior to arranging delivery. The delivery driver used an electronic device to obtain signatures when medicines were delivered. In the event that the medication could not be delivered it was returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs and those requiring cold storage. Fridge temperatures were monitored and recorded daily, and these were observed to be within range. CDs were kept securely

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The RP was unsure of when the store was due to have this available to use.

Stock was date checked by the dispensers. Sections were checked on a weekly basis with the whole dispensary completed over 13 weeks. Stock going out of date was highlighted with a short-dated sticker, recorded and removed. There were no date-expired medicines found on the shelves sampled. A date-checking matrix was in place. Due to the additional workload the team had anticipated with the

switch to the new system, they had completed the date-checking schedule for the next few weeks to free up time.

Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors. Drug recalls were received via alerts from Boots Live or via fax. The RP printed these out and they were signed and dated to show what action had been taken. The last alert for which some action had to be taken was for co-amoxiclav.

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 had a range of clean glass calibrated measures available. Tablet counting trays were available. Separate measures were marked for methadone use only and a separate counter was used for cytotoxic medication to avoid contamination.

Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork/dispensing labels were collected in blue confidential waste bags and then sent to head office for destruction.

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.