

Registered pharmacy inspection report

Pharmacy Name: Boots, 5-6 Lion Walk, COLCHESTER, Essex, CO1 1LX

Pharmacy reference: 1031116

Type of pharmacy: Community

Date of inspection: 20/06/2024

Pharmacy context

This pharmacy is located inside a large Boots store in the centre of Colchester. It provides a variety of services including dispensing NHS prescriptions, the New Medicine Service (NMS) and the dispensing and delivery of medicines for people in care homes in the local area. The pharmacy also provides the Pharmacy First service through Patient Group Directions (PGDs).

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 manages the risks associated with its services well. Team members record any mistakes, and these are reviewed regularly. It has written procedures to help the team work safely which are updated regularly. The pharmacy largely keeps the records it needs to by law. And it has appropriate insurance in place to protect people. The pharmacy handles people's confidential information appropriately.

Inspector's evidence

The correct responsible pharmacist (RP) notice was displayed in the pharmacy. There was a range of standard operating procedures (SOPs) which had been issued by the pharmacy's head office and had been read by all team members. These were available electronically with each team member having their own account. The SOPs were updated regularly by head office. Team members knew their roles and responsibilities in the pharmacy. And the team members were observed working in an efficient and safe manner. The team recorded near misses (dispensing mistakes that were spotted before a medicine left the pharmacy) electronically and records were sent to head office where they were reviewed monthly for any trends. Dispensing errors (mistakes that had reached a person) were also recorded electronically. These were recorded in more detail and these records were also sent to head office for review as well as being discussed with the team. The RP said that there had not been a dispensing error for some time.

Complaints and feedback were usually submitted online. However, the RP said that any complaints or feedback about the pharmacy could also be given in person or via a phone call and would be actioned in the same way. Complaints were usually resolved in store by the store manager but could be escalated to head office if necessary.

Confidential material was disposed of in designated confidential waste bins. When full these were collected by an external company for safe disposal. No confidential waste was found in the general waste bins. And no person-identifiable information could be seen from outside the pharmacy. Team members had completed appropriate safeguarding training with the RP confirming he had completed safeguarding level two with the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy also had a list of local safeguarding services team members could contact if there was a safeguarding issue.

The pharmacy had current indemnity insurance. Balance checks were carried out regularly of controlled drugs (CDs), and records in the CD register were made in accordance with the law. A random check of a CD showed the quantity in stock matched the running balance in the register. Records about private prescriptions were complete with all entries seen having the required details recorded. Records about unlicensed medicines were also generally complete, but a couple of the records seen were missing the name of the patient and the date of supply. The RP said these would be included going forward. The RP record was complete with all entries showing a start and finish time and reasons for absences were regularly recorded.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage its workload effectively. And team members do the right training for their roles. They receive regular ongoing training to keep their knowledge and skills up to date. Team members have no concerns about providing feedback or raising concerns if needed. And targets do not affect the team's ability to provide a safe pharmacy service.

Inspector's evidence

The pharmacy team consisted of three pharmacists, two accuracy checking technicians (ACTs), six dispensers and a healthcare specialist assistant who helped people select and purchase pharmacy-only (P) medicines. The team said the pharmacy had just enough team members to manage the workload and the team was not currently behind on its work. The RP confirmed that all team members had completed a training course or were in the process of completing one with an accredited training provider. Team members were provided with regular e-learning materials from head office. And the RP confirmed that team members had a regular review with head office to discuss their progress. Team members knew what they could and could not do in the absence of an RP. And the healthcare specialist assistant knew what questions to ask people wishing to purchase P medicines. Team members had no issues raising any concerns; they would usually go to the RP or pharmacy manager first but could go to head office if necessary. The RP said the team was set some targets relating to NMS reviews and the Pharmacy First service but said that the targets did not impact the service the pharmacy provided to people.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is generally clean and generally provides a safe and appropriate environment for people to access its services. And the pharmacy is kept secure from unauthorised access. People can speak with a team member in a private area. The pharmacy is mostly tidy. But some areas of the dispensary are cluttered, and the pharmacy could do more to keep these areas clear to prevent potential tripping hazards.

Inspector's evidence

The front fascia of the pharmacy was in a good state of repair and was professional looking. P medicines were stored next to the dispensary counter and there was a team member available to assist people in selecting and paying for medicines. The shelves containing these medicines had roller blinds which were pulled down when the area was not in use and when the pharmacy was closed. The shelves could be seen easily from the dispensary. And P medicines could only be purchased from dedicated tills next to the shelves. The pharmacy had chairs for people who wished to wait to access the pharmacy's services. The pharmacy had a consultation room for people who wished to have a conversation in private. It was bright, clean and allowed for a conversation at a normal level of volume to be had and not be heard from the outside.

The dispensary had plenty of floor and desktop space for team members to work. However, there were some delivery boxes and trolleys scattered around the dispensary which could present a tripping hazard for team members in the pharmacy. The RP said that these would be moved. The temperature and lighting of the pharmacy were adequate and there was air conditioning in the dispensary to help control the temperature. The first floor of the pharmacy had an area where multi-compartment compliance packs and medicines for care homes were prepared. There were staff toilets on the first floor which had access to hot and cold running water and handwash and a large breakroom for team members to use. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its medicines and services safely and it stores medicines appropriately. The pharmacy obtains its medicines from reputable sources. And people with a range of different needs can access its services. The team takes the right action in response to safety alerts and recalls ensuring that people get medicines and medical devices that are fit for purpose.

Inspector's evidence

The store had step-free access via automatic doors. The pharmacy was able to cater for people with different needs, for example by printing large-print labels for people with sight issues. There was enough space for wheelchairs and pushchairs to access the dispensary counter. The dispensary had separate areas for dispensing and checking medicines, and baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines that were seen contained a dispensing label which had the initials of the dispenser and checker, and this provided an audit trail.

Multi-compartment compliance packs and medicines for care home residents were prepared in a separate room. A check of completed packs showed that they contained all the necessary dosage instructions and safety information. They also had a description of the colour, shape and any markings on the medicines to help people identify their medicines. Team members confirmed that patient information leaflets (PILs) were always included with the packs. Team members also confirmed that they would contact the surgery regarding any queries they had with prescriptions such as unexpected changes to people's treatment. A similar process was also followed for supplies of medicines to care home which were dispensed in the same room before being packaged up for delivery to the care homes. A Medicines Administration Record (MAR) chart was provided by the pharmacy for all care home residents that the pharmacy provided medicines for. The pharmacy provided a delivery service to people who had difficulty collecting their medicines. The delivery driver used a secure electronic device to keep a record of deliveries. The pharmacy also kept a paper record of deliveries. If there was a failed delivery, a note was put through the door to arrange redelivery and the medicines returned to the pharmacy. For deliveries containing CDs, the person receiving the delivery had to sign to confirm receipt.

The pharmacy used cards to highlight prescriptions that contained a high risk medicine requiring pharmacist intervention or counselling. The RP stated that he would regularly counsel people taking high-risk medicines and would confirm with the GP surgery if the relevant tests had been done. The pharmacy obtained medicines from licensed wholesalers and invoices were seen confirming this. CDs requiring safe custody were stored securely. And dates were written on CD items to help reduce the chance of prescriptions being handed out when they were no longer valid. Medicines requiring refrigeration were stored appropriately. Fridge temperatures were checked and recorded daily, and records seen were all in the required range. The current temperatures were found to be in range during the inspection. Expiry-date checks were carried out weekly on a rota basis with a different section being checked each time. A random check of medicines on the shelves found no out-of-date medicines. Liquid medicines were marked with the date of opening so dispensers could assess if they were still suitable to use.

Safety alerts and recalls were received electronically. These were printed and actioned as appropriate

with the action taken being documented on the alert form before being archived in a folder. The RP was aware of the risks with sodium valproate and knew what to do if a person in the at-risk category presented at the pharmacy with a prescription for sodium valproate. Team members were shown where to apply a dispensing label to a box of sodium valproate so as not to cover any important safety information. And the team was aware of the recent guidance change with regards to supplying sodium valproate in its original package. The RP confirmed the pharmacy didn't currently supply valproate-containing medicines to anyone in the at-risk group. The pharmacy had PGDs for providing the Pharmacy First Service and COVID-19 vaccinations. The PGDs were in date and had been signed. There was a suitable in-date anaphylaxis kit available in the consultation room should a person experience an anaphylactic reaction to a vaccination.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide a safe and effective service. And it uses its equipment to protect people's privacy.

Inspector's evidence

The pharmacy had computers with access to the internet, allowing team members to access any online resources they needed. Computers were password protected and faced away from public view to protect people's privacy. The pharmacy had cordless phones to allow conversations to be had in private. Team members were observed using their own NHS smartcards. Electrical equipment had been safety tested recently and there were stickers on the equipment to confirm this. The pharmacy had appropriate glass measures for measuring liquids with separate ones marked for certain liquids only. And it had triangles for counting tablets and a separate one for cytotoxic medicines such as methotrexate to prevent cross-contamination. The pharmacy had a blood pressure machine in the consultation room. The RP confirmed that it was only a few months old and so did not require replacement or recalibration. There was also an otoscope in the consultation room for use with the Pharmacy First service.

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.