General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2, The Royals Shopping Centre, High Street, SOUTHEND-ON-SEA, Essex, SS1 1DE

Pharmacy reference: 1031415

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

The pharmacy is located on a busy shopping centre in a large town centre. It receives around 75% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations. It uses Patient Group Directions to provide medicines for hair retention, travel vaccinations, meningitis B, the HPV vaccination, anti-malarials, cystitis testing and treatment and a stop smoking service (Champix and nicotine replacement medicines). It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And also supplies medicines to a large number of care homes. It provides substance misuse medications to a large number of people and also has a needle exchange 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It largely protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. The pharmacy mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included: documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that they had read and understood them. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where a person's medicine had been given to the wrong person. The person returned the medicine to the pharmacy and the pharmacy recorded the incident on the pharmacy reporting system and informed head office. The person who had handed out the medicine had not initialled to show that they had done this. The pharmacist said that she knew who it was, and she would remind them about ensuring that they initialled the prescription. Pharmacist's information forms were routinely used to ensure important information was available throughout the dispensing and checking processes. A quad stamp was printed on prescriptions and dispensing tokens; staff usually initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out).

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Trays were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checkers knew which prescriptions they could check and prescriptions were clinically checked before they were dispensed.

Team members' roles and responsibilities were specified in the SOPs. One of the pharmacy advisers said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. Another pharmacy adviser knew that she should not carry out any dispensing tasks if the pharmacist was not on the premises and there was no second pharmacist.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made and there were signed in-date Patient Group Directions available for the relevant services offered. The

private prescription records were mostly completed correctly, but the prescriber's name and appropriate date on the prescription was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. The pharmacy adviser said that she would remind team members to include all the required information in the future. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not always recorded. The CD running balances were checked at regular intervals and liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist said that she would remind team members to record the address of the supplier in the future. The right responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. But the pharmacist had not completed the log at the start of her shift, she entered her details at the start of the inspection.

Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and over 92% of respondents rated the pharmacy as excellent or very good overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. And the pharmacy's customer services number was printed on the till receipts. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. The pharmacy advisers could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members can raise any concerns or make suggestions and have meetings to discuss these. This means that they can help improve the systems in the pharmacy. They can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets. Team members are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And the team discusses adverse incidents and uses these to learn and improve.

Inspector's evidence

There were two pharmacists, nine trained pharmacy advisers and the assistant manager (trained pharmacy adviser) working in the main dispensary during the inspection. The pre-registration trainee was not working at the pharmacy on the day of the inspection. The assistant manager said that she often worked in the dispensary during busy periods. And the store manager said that she would also help in the dispensary when needed. Team members had completed accredited courses for their roles. Two of the pharmacy advisers were enrolled on the NVQ level 3 pharmacy course. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The pharmacy advisers appeared confident when speaking with people. One, when asked, was aware of the restrictions on sales of pseudoephedrine containing products. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She counselled people on how to take the medicines they were purchasing at the medicines counter, and ensured that they were aware of certain conditions which might be affected by some of the medicines.

Team members were provided with ongoing training and this was monitored by the store manager. There were no set times during the working day to complete these and usually had to complete them in their own time or at home. The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she said that she felt able to take professional decisions. The pharmacy regularly reviewed any dispensing mistakes and these were discussed openly in the team.

Team members had yearly appraisals and performance reviews with the store manager. They felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy received a regular newsletter from the pharmacy's head office, which included any issues or changes to procedures. Team members usually tried to have any meetings after work so that there were no interruptions.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that was a certain amount of pressure to achieve the targets, but she would not let this affect her professional judgement. She explained that she carried out the services for the benefit of the people using the pharmacy and not to meet the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter, but there was no barrier to restrict access behind the counter at one side. And some pharmacy-only medicines were potentially accessible to people using the pharmacy. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

The layout of the dispensary counter meant that some people’s personal information and medicines were potentially accessible and visible. The dispensary counter was often used for dispensing medicines. Prescriptions waiting collection were kept on the dispensary counter at the start of the inspection and these were potentially accessible to people using the pharmacy. The pharmacist moved these so that they were more secure. And she said that the dispensary counter was not left unattended wherever possible and items were not routinely left unattended on the counter.

There were three chairs in the shop area and one had arms to aid standing. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loops appeared to be in good working order. An appointment system was used for the services, to ensure that there was a pharmacist available who could provide the services.

The pharmacy adviser said that monitoring record books were checked for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the relevant patient information leaflets or warning cards available. The pharmacist said that she would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked weekly using the colour-coded retrieval system. People were sent weekly text messages to remind them about their uncollected medicines. If the person had not collected their medicines after around five weeks, their medication record would be updated. Any uncollected items were returned to dispensing stock where possible and the prescriptions were kept at the pharmacy until the prescription was no longer valid. So that these could be re-dispensed if the person came to collect their medicines. People were informed and prescriptions for alternate medicines were requested from the prescribers where needed.

Multi-compartment compliance packs were assembled in rooms upstairs to help minimise distractions. Team members said that assessments for the people who had their medicines in these packs were

carried out by the person's GP or by the pharmacist. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the pharmacy adviser said that the pharmacy contacted people to see if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

The care homes were responsible for ordering prescriptions for their residents. The pharmacy received lists of items which had been ordered from most of the large care homes. These were used to check against prescriptions received, so that the pharmacy could inform the care home if items were missing off the prescriptions. Communication folders were used for each care home and a book was also used to ensure that any important information was available for all team members. Team members initialled the dispensing labels and packs were suitably labelled. The accuracy checker said that the pharmacy would soon supply medicines in original packaging to the care homes.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy or another pharmacy within the organisation before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacist said that the pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. And she confirmed that team members had not received any training for this. She was not sure when the pharmacy was due to have the equipment installed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for liquid controlled drug use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.