General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 Silva Island Way, WICKFORD, Essex, SS12 9NR

Pharmacy reference: 1031448

Type of pharmacy: Community

Date of inspection: 28/06/2024

Pharmacy context

This is a small branch of the Boots pharmacy chain located in Wickford, Essex in a parade of shops. It dispenses people's prescriptions, sells over-the-counter medicines and provides health advice. It offers New Medicine Service (NMS) checks, emergency hormonal contraception, blood pressure checks, and consultations and some medicines through the Pharmacy First service. And it also offers flu vaccinations during the autumn and winter seasons.

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 uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. It generally manages and protects confidential information well and tells people how their private information will be used. People using the pharmacy's services can easily provide feedback. Team members have the relevant training to safeguard the welfare of people using their services. The pharmacy mostly keeps the records it needs to by law. But doesn't consistently review mistakes that happen during the dispensing process. And this may mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had Standard Operating Procedures (SOPs) in place to help its team members carry out activities. Each team member could refer to these through the pharmacy computer or through their personal devices. The pharmacy technician said that everyone was up to date with reading and signing the SOPs relevant to their roles. As the store did not currently have its own manager, the pharmacy was supported by a store manager from another branch nearby who ensured that the team received alerts of when SOPs or training required completion. The SOPs were regularly reviewed and updated centrally. Those team members questioned were all clear on the correct procedures to follow and their roles and responsibilities. Staff were able to describe what action they would take in the absence of the responsible pharmacist (RP), and they explained what they could and could not do. A business contingency folder was in place. This contained emergency contact details, actions to take in a number of situations, and posters for signposting people to the next nearest pharmacy if required.

The pharmacy technician said that dispensing mistakes that were identified before reaching a person (near misses) were recorded online using the Datix platform. This was usually recorded by the person who made the mistake, to encourage ownership and learning. They explained that due to the lack of leadership a review of these mistakes had not been completed in recent months, with the last known review being in December 2023. When asked, team members could not describe any actions they had taken to minimise near misses. The lack of regular review may mean that opportunities to identify trends or patterns in mistakes are missed. There had been no reported dispensing mistakes which had reached people (dispensing errors). However, team members explained that these would be recorded online on the Boots PIERS platform for onward reporting centrally to the NHS 'learn from patient safety events' (LFPSE) service. These mistakes would also be escalated to their area manager, and depending on severity of the incident, the superintendent pharmacist (SI). The pharmacy technician explained that the newly introduced Advanced Due Date Dispensing (ADDD) process had reduced the number of mistakes, but increased the time it took for the team to process the workload. A monthly newsletter was circulated by head office to highlight learnings from across the organisation.

The RP sign was correct and visible at the time of inspection and the RP record was completed fully. Private prescription records were held electronically, and the sample of records for private prescriptions inspected were complete with all the necessary details correctly recorded. Documentation for unlicenced medicines were generally well maintained. The pharmacy technician said that emergency supply records were also maintained electronically but explained that they did not make many emergency supplies. The team did not know how to access the emergency supply records, this may mean that this information would be harder to find out if there was a query. The pharmacist

described the circumstances for when an emergency supply might be issued and described how this would be completed on the patient medication record (PMR) system with details of the emergency and a reason for supply.

The required entries had been made in controlled drug (CD) registers that were seen and a random physical check of two CD medicines matched the balance recorded in the register. CD balances were checked regularly as stated in the SOP and there was clear documentation of recent balance checks. When asked, the dispenser could describe the checks made at handout of a CD, including confirming the identity of the person or representative, checking the relationship to the patient, and obtaining a signature for proof of collection.

A current indemnity insurance certificate was held centrally. Feedback or complaints from people using the pharmacy's services could be received verbally in person, by telephone or through an online form on the pharmacy's website. There was a complaints procedure in place, and this was detailed in a store overview leaflet. It included contact details for the company's head office and privacy notice. If a complaint was received, team members could escalate issues to the area manager, and they were supported by a store manager from another Boots pharmacy close by. A data processing notice was displayed beside the counter and team members had completed information governance training through the Boots e-learning system. Confidential waste was kept separate from general waste and shredded offsite. Completed prescriptions awaiting collection were stored out of sight of people waiting at the counter.

The pharmacy team members understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. The pharmacy technician explained in the past they had looked up the contacts for local safeguarding boards to escalate a concern and team members were aware they could escalate to the pharmacist. The RP had completed level two safeguarding training and was in the process of completing level three through the NHS e-Learning for Healthcare (e-LfH) system. All other team members had completed training through the Boots e-learning system.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open and honest environment. Team members do not always get protected time to do ongoing learning. This may make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

The team on the day of inspection comprised a relief pharmacist, a pharmacy technician and two dispensers (one of whom mostly covered the healthcare counter). All team members had completed an accredited course for the roles they undertook. The pharmacy currently had a vacancy for a store manager, and the pharmacy technician had taken on some additional responsibilities, with the support of another local store manager. The team had designated activities to complete to ensure that the workload was completed efficiently.

The team was up to date with dispensing prescriptions with no backlog of work. When questioned, the dispenser covering the healthcare counter was able to demonstrate an awareness of medicines with the potential for abuse and could identify people making repeat purchases. They knew the correct lines of questioning when selling medicines or providing advice and knew when to refer to the pharmacist. The RP reported feeling comfortable in using their professional judgement when decision making and did not let company targets impede this. The team reported that they did not get designated training time in work hours. But had access to a range of resources to ensure continued learning and development which they often completed outside of work hours.

The relief pharmacist explained that their appraisals were conducted annually, and they were given the opportunity to make suggestions and raise any concerns with their line manager. Other team members said that they had not had the opportunity for a formal appraisal but said they felt able to raise concerns with the RP and supporting store manager. The team members described working openly and honestly with each other and had informal discussions around concerns and feedback. The pharmacy technician participated in a messaging group where information was shared between local Boots pharmacies. For example, this included communications about stock shortages, to aid in signposting people for medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe and appropriately maintained. It has enough dispensing space for people to work safely. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

There was a dispensary on a raised platform at the rear of the premises, this allowed team members to see people entering the pharmacy and protected confidentiality. The dispensary had many baskets containing prescriptions awaiting a final accuracy check, but it was well organised with separate assembly and checking areas. Completed prescriptions that were awaiting collection were stored appropriately to ensure that people's information was not visible from the retail area. There was a notice board to highlight patient safety work and pharmacy priorities, however the resources displayed were from some time ago.

Pharmacy-only medicines were kept behind the counter. There was a suitably sized consultation room for confidential conversations and providing services, which was accessible from the shop floor. There was no confidential information on view inside the consultation room. A small desk, with two chairs and a password-protected computer was available inside.

The premises were clean and generally tidy. The team had a cleaning rota and were in the process of re-organising the dispensary to help with workflow. There was good ventilation, and the premises were well-lit. The temperature was suitable for storing medicines. Handwashing facilities were available in the dispensary, and a staff toilet with separate handwashing facilities was available to the rear of the property.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to a wide range of people and it delivers its services in a safe and effective manner. It obtains its medicines from reputable sources and manages them appropriately so that they are safe for people to use. Its team members identify people taking higher-risk medicines and provides them with appropriate advice. This helps make sure that these medicines are taken safely.

Inspector's evidence

The pharmacy had single-door step-free access just large enough for people with wheelchairs or pushchairs. There was a reasonably sized retail area with some seating for people awaiting service. The RP was multi-lingual and large-print labels were available on request.

Medicines were sourced from licensed suppliers. A random spot check of stock revealed no out-of-date medicines and the dispenser said that regular checks for short-dated medicines were completed as per the company's checklist. A matrix for recording checks was not seen during the inspection, however items with short dates were seen to be recorded on monthly sheets, so that team members knew when to dispose of these. Dates of opening for liquid medicines were generally written on the bottles to help staff know if they were still suitable to use. A full medicinal waste bin was stored in the staff toilet; this was rectified during the inspection. People’s details were still attached to medicines waste inside the bins. The pharmacy technician gave assurances that these would be obliterated or removed prior to collection by an external contractor. CDs were stored securely with expired and returned CD medicines separated in clearly marked bags while awaiting destruction. Temperature check records for the fridge were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the Boots online hub and Boots live. The pharmacy technician explained that these were highlighted in red when team members logged in to their accounts. The system required the name of the person actioning the alert to be entered and a box to be ticked if stock was found for a recall. All team members were required to log on to the Boots hub daily to ensure that alerts were not missed. However, the team could not access an audit trail of the action taken, which may make it harder for the pharmacy to show what it had done in response. The pharmacy technician said that she was in the process of getting access to some pharmacy data, including reports and audit trails, which she did not currently have due to there being no store manager at present.

There were controls in place to help minimise errors, such as using baskets for each prescription so that their contents were kept separate from other prescriptions. Dispensing labels included ‘dispensed by’ and ‘checked by’ boxes to indicate who had carried out those tasks. The pharmacy also annotated the prescription tokens to show who had carried out the clinical check on each prescription. Any points the pharmacist needed to be aware of were also printed on a label that was stuck to the token. This was generated from the PMR system and included dose changes and people eligible for the New Medicine Service (NMS). The RP explained that prescriptions for higher-risk medicines were also highlighted using these labels created by the PMR, and relevant blood results were recorded where available. Bright coloured laminates were also attached to the prescription token to prompt the pharmacist to provide appropriate advice and counselling to people receiving these medicines. Team members were aware of

the risks involved when supplying valproate products to people who could become pregnant. The RP explained that they would check if people were on a Pregnancy Prevention Programme (PPP) where necessary and record interventions on the PMR system. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels.

For the ADDD process, prescriptions were clinically checked before the data was entered into the PMR system and then they were checked for accuracy before the stock order was transmitted to the wholesaler. Once the stock was delivered, team members scanned the barcode on each item to identify which prescription it related to and which storage location it should be placed in once labelled. Both the label's barcode, and the pack's barcode were scanned to ensure they matched. The prescription barcode was also scanned, again identifying the storage location where the items themselves had been placed. As indicated under principle one, the team explained that this process had reduced the number of errors. However, the dispenser commented that if not all of the stock arrived in the allocated tote from the wholesaler, then this delayed the dispensing and checking process, impacting workflow.

Uncollected prescriptions were removed from the shelf periodically around every four weeks. The dispenser explained that if there was a contact number available on a persons PMR then they would text them a collection reminder. Once removed, medicines were returned to the stock where possible and the prescription was marked as not dispensed through the PMR system which was linked to the NHS spine.

Patient Group Directions (PGDs) for the Pharmacy First service were printed for reference in a folder in the consultation room. The RP explained that following training through the Boots Academy and the Centre for Postgraduate Pharmacy Education (CPPE), a declaration was completed online to work under the PGDs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use and uses it to help protect people's personal information.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids, and clean tablet and capsule counters were available for dispensing loose medication. A separate tablet counter for cytotoxic medication was available. A new otoscope was on hand with disposable specula covers for providing the Pharmacy First service. A sharps bin and an in-date anaphylaxis kit were available in the consultation room for when vaccinations were administered.

The RP said that the blood pressure monitor was calibrated, but if the monitor was showing inconsistent readings, then they could take a new monitor from the retail area. Ambulatory blood pressure monitors were not held in store but could be requested through head office if required for a person needing the service.

Team members had their own NHS smartcards, for accessing electronic prescriptions. All computers were password protected to safeguard information, and a portable telephone enabled the team to ensure conversations were kept private were necessary. Electrical equipment was safety tested and fire extinguishers were available at the rear of the premises behind the dispensary.

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.