

Registered pharmacy inspection report

Pharmacy Name: Boots, 57 High Street, STROUD, Gloucestershire,
GL5 1AS

Pharmacy reference: 1031588

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This is a community pharmacy in the centre of the town of Stroud. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines and many other items. The pharmacy offers a good range of services. It also supplies several medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. And it supplies medicines for the residents of some local care homes.

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	Good practice	1.1	Good practice	The pharmacy team members complete competency assessments to show that they fully understand the company's written procedures.
		1.2	Good practice	The pharmacy team learn and act on mistakes to prevent them from happening again.
		1.4	Good practice	The pharmacy proactively encourages feedback from people and uses this to improve its services.
2. Staff	Good practice	2.1	Good practice	The pharmacy has good staffing levels for their workload. And, it has procedures in place to cover team members who are sick, on extended leave or on holiday.
		2.2	Good practice	The team members are encouraged to keep their skills up to date and they are given time to do this at work. Those team members who are in training are well supported and are allocated additional learning time.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.1	Good practice	The pharmacy offers a good range of services and everyone can access these.
		4.2	Good practice	The team members make sure that people have the information that they need to use their medicines properly. They intervene if they are worried about anyone. And, anyone taking high-risk medicines are targeted for counselling.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Good practice

Summary findings

The pharmacy's working practices are safe and effective. The team members complete competency assessments to show that they fully understand the company's written procedures. They also learn and act on mistakes to prevent them from happening again. The pharmacy proactively encourages feedback from people and uses this to improve its services. It is appropriately insured to protect people if things go wrong. The team members keep the up-to-date records that it must by law. They also keep people's private information safe and know how to protect vulnerable people.

Inspector's evidence

The pharmacy team identified and managed risks. Dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a recent quantity error. Because of this, quantities were now initialled on the prescription and on the label to demonstrate that they had been thoroughly checked. In addition, 'split' quantities were written on the inner tab of the box. Near misses were recorded in the two dispensing areas, the downstairs dispensary and the multi-compartment compliance aid and care home room. Learning points and actions were recorded to reduce the likelihood of recurrences. The near miss log was reviewed by the pharmacist each month as part of a patient safety review. In the latest review, it had been identified that several errors were form errors for the compliance aids. Because of this, the stock for the compliance aids was now checked prior to filling. The risk of picking errors with 'look alike, sound alike' drugs was identified such as propranolol and prednisolone. The Superintendent's Office had recently sent a laminated sheet containing several such drugs. These were displayed near all the computer monitors with instructions that they should be highlighted on the 'Pharmacist information Forms' (PIFs) that were attached to all prescriptions. The Superintendent's Office also sent monthly professional standards bulletins which all the staff signed to demonstrate that they had been read. The current bulletin was displayed.

The downstairs dispensary was limited in size, but the space was well utilised. It was tidy and organised with labelling, assembly, waiting to be checked and checking areas. Upstairs, there was a spacious, organised room with separate areas for the compliance aids and the care homes. A central bench was used for checking with shelving below for items that were waiting to be checked. This kept the central bench clear. There was also a separate area for any interim prescriptions for the homes.

Coloured cards were used which highlighted, amongst others, patients who were waiting, those calling back and prescriptions containing fridge items, paediatric doses, warfarin, methotrexate and controlled drugs. All assembled prescriptions examined had a completed PIF where any relevant information was recorded. High-risk drugs and high-risk patients were identified and appropriately counselled.

There was a clear audit trail of the dispensing process and all the 'dispensed by' and 'checked by' boxes on the labels examined had been initialled. In addition, all prescriptions contained a four-way stamp which included the initials of who had done the clinical check, the dispensing, the accuracy check and the hand-out or the 'priming' for the care homes. Regular audits were undertaken by the area manager. Risk assessments were performed, such as, one in September 2019 prior to the seasonal flu vaccination service being offered.

Up-to-date, signed and relevant Standard Operating Procedures (SOPs), including SOPs for services

provided under patient group directions, were in place and these were continually reviewed by the Superintendent Pharmacist. The staff completed competency assessments on the SOPs to ensure that they fully understood them. The roles and responsibilities were clearly set out in the SOPs and the staff were clear about their roles. A care card for medicines sales was displayed close to the medicine counter. This included local additions, such as, Phenergan. A NVQ2 qualified dispenser reported that she would refer all requests for customers on prescribed medicines to the pharmacist. 'Care cards' were attached to the storage positions of items that should be referred to the pharmacist, such as, 'prescription only medicine' (POM) to 'pharmacy only medicine' switches, such as Ella One and fluconazole capsules and items like Solpadeine Plus. The staff were also prompted by a message on the till to refer the sale of some items to the pharmacist.

The staff were clear about the complaints procedure and reported that feedback on all concerns was actively encouraged. The company operated a continual feedback procedure and till receipts gave instructions on how to provide feedback and raise concerns. All feedback was collated by the company's Head Office and passed onto the store if appropriate. In addition, there were cards close to the till giving customers instructions on how to provide feedback. The store manager looked at this feedback regularly. An annual pharmacy specific customer satisfaction survey was also done. In the 2019 survey, 88% of customers who completed the questionnaire rated the pharmacy as excellent or very good overall. 6% of people had provided feedback about the pharmacy having medicines in stock. Because of this, the pharmacy tried to sign up any appropriate people to their managed repeat prescription service where regular medicines were ordered well in advance. They also kept good stock levels of common items but, said that they had several 'walk-in' prescriptions and sometimes they did not have the prescribed medicine. A text service was offered whereby a message was sent to patients letting them know that their prescriptions or items that were owed to them were ready to collect.

Current public liability and indemnity insurance was in place. The Responsible Pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, fridge temperature records, specials records and date checking records were all in order.

An information governance procedure was in place. All the staff had completed training on the general data protection regulations. The pharmacy computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Sensitive telephone calls were taken in the consultation room or out of earshot. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had completed the company's e-Learning module on the safeguarding of both children and vulnerable adults. The pharmacists and technician had also completed training provided by the Centre for Pharmacy Postgraduate Education (CPPE). The procedures to follow in the event of a safeguarding concerns were available as were the local telephone numbers to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy has good staffing levels for their workload. And, it has procedures in place to cover team members who are sick, on extended leave or on holiday. The team members are encouraged to keep their skills up to date and they are given time to do this at work. Those team members who are in training are well supported and are allocated additional learning time.

Inspector's evidence

The pharmacy was in the centre of the town of Stroud. They mainly dispensed NHS prescriptions. A large proportion of the business at the pharmacy was the assembly of medicines into compliance aids for domiciliary patients and medicines for care home (nursing and residential) residents. Due to the location of the premises, there were several acute 'walk-in' prescriptions.

The current staffing profile was: two full-time pharmacists, one replacing an accuracy checking technician (ACT) who was on extended leave, one full-time NVQ3 qualified technician, three full-time NVQ2 qualified dispensers, one of whom was a trainee technician and also the manager, two part-time NVQ2 qualified dispensers, one of whom was the assistant manager, two part-time NVQ2 trainee dispensers and one full-time delivery driver. All the staff covered the medicine counter. The store manager and assistant manager were often occupied with managerial duties but able to work in the dispensary when necessary. This gave flexibility to cover both planned and unplanned absences. The time of the ACT, on extended leave, had been replaced with an additional pharmacist. And, the pharmacy could call on the help of relief dispensers in the area if necessary. The part-time staff were also flexible. Planned leave was booked well in advance and only one member of staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff worked well together as a team. Their performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and completed regular e-Learning. The staff said that they spent about 30 minutes each week of protected time learning. Staff enrolled on accredited courses, such as the NVQ3 trainee technician course, were allocated further time for learning. All the staff said that they were supported to learn from errors. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. The manager was very newly appointed. She said that she planned weekly 'huddles' and more formal monthly meetings. The regular pharmacist said that she was set overall targets, such as for Medicine Use Reviews (MURs). She said that she only did clinically appropriate reviews and did not feel unduly pressured by the targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it provides. It signposts its consultation room well, so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and well maintained. There were two chairs, covered with fabric, for people who were waiting. These may be difficult to keep clean. The store manager said that she would get these changed to wipe-able chairs.

The consultation room was small but the door opened outwards and so, access by the emergency services, if necessary, should not be impeded. The room was well signposted. There was no computer or sink. The pharmacy did offer vaccination services, Medicines Use Reviews and the Community Pharmacy consultation Service (CPCS). The manager said that the pharmacists could use the pharmacy's iPad for the latter service and that it was planned that a computer would be installed in April 2020. The door to the room was clear glass but there was a curtain which allowed maintenance of patient confidentiality. Conversations in the consultation room could not be overheard. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. The general medicine aisles were in the close vicinity of the pharmacy.

Principle 4 - Services ✓ Good practice

Summary findings

The pharmacy offers a good range of services and everyone can access these. It manages all its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to use their medicines properly. They intervene if they are worried about anyone. And, anyone taking high-risk medicines are targeted for counselling. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room with automatic opening front door. The store had a translation application on their iPad for non-English speakers. The pharmacy could print large labels for sight-impaired patients. A portable hearing loop was available.

Advanced and enhanced NHS services offered by the pharmacy were Medicine Use Reviews (MURs), New Medicine Service (NMS), Community Pharmacy Consultation service (CPCS), emergency hormonal contraception (EHC), palliative care, supervised consumption of methadone and buprenorphine and seasonal flu vaccinations. The latter was also provided under a private agreement as was vaccination against pneumonia. Malaria prophylaxis was given against private prescriptions generated by the company's online doctor service.

The regular pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis and training on the provision of the free NHS EHC service. She had also completed the Gateway training on the prophylaxis of malaria. The Fit-for-Travel and company's websites were consulted to ensure that the prescribed medicine was appropriate. Recently, she had completed training on the new CPCS scheme. The pharmacist said that they had had a few referrals since the service became operational.

A large proportion of the business at the pharmacy was the assembly of medicines into compliance aids for domiciliary patients and the assembly of medicines for the residents of several care homes (nursing and residential). These were assembled in a spacious, organised room upstairs.

The domiciliary compliance aids were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. There was a clear progress log of the entire process. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. The company had introduced new procedures for the domiciliary trays. This required that, following any changes, a new sheet was to be completed. The old sheets were kept, but potentially the poly-pockets could become overly full. Changes were also written on a communication sheet which was also kept in the poly-pockets. However, the pharmacy had a clear concise audit trail of changes for easy reference by the checking pharmacist. The surgeries informed the pharmacy about blood tests for those patients prescribed high-risk items such as lithium.

Services for the care homes were well organised. The medicines were supplied in original packs. The pharmacy kept a copy of any communication with the homes in date and home order in well organised, dedicated files. The homes ordered the prescriptions on behalf of their patients and copies of the

prescriptions were sent to the homes for checking. The pharmacy sent query sheets to the homes about any changes, missing items or other issues, including queries about up to date international normalised ratios (INR) for patients prescribed warfarin. The surgeries did not always send the pharmacy written confirmation of any changes. The homes were visited quarterly to check on medicines management and other issues. The staff at the homes followed the company training which included some face-to-face training. The pharmacy staff gave any required advice over the telephone if necessary.

The pharmacy had a few substance misuse patients, some of whom had their medicines supervised. The supervised patients were offered water, chewing gum or engaged in conversation to reduce the likelihood of diversion. Any concerns about these patients were recorded on their electronic prescription medication record.

There was a good audit trail for all items dispensed by the pharmacy. The pharmacists routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. Most acute 'walk-in' patients were counselled. The pharmacists also counselled patients prescribed amongst others, antibiotics, new drugs, the parents of children, complex dosages and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidelines relating to the pregnancy protection programme. Two 'at risk' patients had been identified. Both of these were residents in a care home. The carers had been appropriately counselled and guidance leaflets were included with each prescription for them.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist on the PIFs. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Suitable patients were encouraged to use the company's managed repeat prescription service so that all regular prescribed items ran in line to reduce wastage, to optimise the use of medicines and to identify any non-adherence issues. Patients were asked to check when they collected their medicines if they still needed everything that they had ordered the previous month. Any patients giving rise to concerns were referred to the pharmacist for counselling.

The regular pharmacist said that many of the patients using the pharmacy suffered with cardio-vascular problems. She said that they were generally well informed. She did sometimes identify side effects due to simvastatin during MURs which she escalated to the patient's doctor with their consent. The dose of simvastatin was often subsequently reduced or an alternative statin was prescribed.

Medicines and medical devices were obtained from Alliance Healthcare, AAH and Boots Head Office. Specials were obtained from Alliance Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned CDs but a few out-of-date CDs. These were well labelled and well separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Other stock was stored tidily on the shelves. Date checking procedures were in place with signatures recording who had undertaken the task. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and list of such substances that should be treated as hazardous for waste purposes. The pharmacy staff were aware of the Falsified Medicines Directive but the pharmacy was not currently using a scanner to check for falsified medicines.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts received electronically, printed off and the stock checked. They were signed and dated by the person

checking the alert. Any required actions were recorded. The pharmacy had received an alert on 5 February 2020. The pharmacy had one packet of affected stock. This was returned to the wholesaler.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that it is clean and fit-for-purpose.

Inspector's evidence

The pharmacy had a number of British Standard crown-stamped conical measures (10 - 250ml). There were several tablet-counting triangles, some of which were kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF. There was access to the internet and to Medicines Complete.

The fridges were in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.