General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 292-294 London Road, WATERLOOVILLE, Hampshire, PO7 7DS

Pharmacy reference: 1031937

Type of pharmacy: Community

Date of inspection: 28/02/2020

Pharmacy context

A Boots community pharmacy. The pharmacy is on the pedestrianised high street running through the centre of Waterlooville. As well as the NHS Essential Services, the pharmacy provides medicines in multi-compartment compliance aids for people living locally. It also provides a seasonal flu vaccination service and substance misuse support services including supervised consumption. Other services include; Medicines Use Reviews (MURs), a New Medicines Service (NMS) and emergency hormonal contraception (EHC). The pharmacy is due to launch a cystitis treatment service within the next week.

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's working practices are safe and effective. Its team members understand their responsibilities in helping to protect vulnerable people. They listen to people's concerns and keep their information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP) whose sign was displayed for the public to see. There was a set of up-to-date standard operating procedures (SOPs) in place. Staff had read and signed the SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and recorded as soon as possible afterwards. The accuracy checking technician (ACT) said that they discussed all near misses with the individual involved, as soon as the near miss came to light. The team also had regular meetings to review and discuss any mistakes and ways of preventing reoccurrence. The pharmacy received regular training articles and updates from the pharmacy superintendent's office.

Staff described how they had reorganised the storage of prescriptions for delivery following an incident. Separate storage areas had been set up for multi-compartment compliance packs for weekly delivery, monthly delivery and deliveries of non-compliance pack prescriptions. Staff had also date checked, tidied, and reorganised the pharmacy's stock. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs) such as amitriptyline and atenolol, aspirin dispersible and aspirin GR. The pharmacist had placed a list of LASAs on computer monitors and in dispensing areas as a reminder. And when a LASA was prescribed staff would generally add a note to the pharmacist's information form (PIF). Examples were seen where this had been done but also two examples were found where this had not been done (allopurinol and atenolol). However, mistakes in general had reduced in recent months, including incidents involving LASAs. The most common near misses in the current month related to the form or strength of drug dispensed. Records showed that discussions were had with staff at the time to raise awareness of the different forms of drugs and to check quantities. The system for recording near misses showed who was involved, and what happened, but the section for identifying and recording possible causes was largely empty. More detail may help the team to further reflect on what had gone wrong. And help it identify any mistakes before transferring the dispensed item to the RP for an accuracy check. Staff had placed a picture card of the company's accuracy checking tool on display in the area where multi-compartment compliance packs were dispensed, but not in the main dispensary.

The pharmacy had a documented complaints procedure. Where possible, customer concerns were dealt with at the time by the regular RP. Formal complaints and dispensing incidents would be recorded and referred to the superintendent. Details of the procedure were available in a SOP. And contact details for the local NHS advocacy service and PALS could be provided on request. Details of NHS England and local Healthwatch were available on an 'about this pharmacy' leaflet which was on display for selection. The leaflet also contained, a phone number for the Boots customer care service, at head office. The pharmacy had professional indemnity and public liability arrangements, so they could provide insurance protection for staff and customers. Insurance arrangements were renewed annually.

All the necessary records were kept and were in order including Controlled Drug (CD) registers. Records for private prescriptions, emergency supplies, the RP and unlicensed ‘Specials’ were also in order. The pharmacy had records for CDs returned by people, for destruction. Records of returned CDs were kept for audit trail and to account for all the non- stock CDs which RPs had under their control.

Staff had undergone Information governance training and had completed the Boots online ’e-learning’ module. Discarded labels and tokens were disposed of in a separate, blue, confidential waste bag in a confidential waste bin. And collected for safe disposal by a licensed waste contractor. Completed prescriptions were stored in drawers in the dispensary near the counter. Drawers were deep enough to hide any patient or prescription details from people’s view. The pharmacy had a pull-out tape barrier to prevent people from leaning over and looking at the prescription storage area.

The regular pharmacists had completed CPPE level 2 training on safeguarding. All staff had been briefed on the principles of safeguarding and completed the Boots online ’e-learning’ module and dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough staff to manage its workload safely. Team members can make suggestions and get involved in making improvements to the safety and quality of services provided. They work effectively together in a supportive environment.

Inspector's evidence

The pharmacy generally had two regular responsible pharmacists (RPs). One full-time and one part-time. But on the day of the inspection the RP was a Boots locum. The RP was supported by an ACT, a dispenser and a trainee pharmacy advisor. The store manager, who was a dispenser was also present. In general, the pharmacy had enough staff to manage its workload safely. Although on the day of the inspection the team was short-staffed, and the daily workload of prescriptions was not fully up to date. The pharmacist was observed checking a backlog of repeat prescriptions from the preceding 3 days, whilst also checking waiting prescriptions. Team members were also continuing to download and dispense electronic prescriptions from that day as well as dealing with 'walk-in' prescriptions as they came in. The ACT was not currently accuracy checking prescriptions as there were some members of the team at the early stages of their training. The situation would be reviewed once the team was appropriately trained and skilled and the ACT's own checking skills reviewed. But team members were observed to work effectively together and felt that they would be able to catch up on the prescription backlog within a few days. They were seen assisting each other when required and customers were attended to promptly. Recent training covered by staff included sepsis awareness, risk management and LASAs. Other training included activity sheets on children's doses. The pharmacy superintendent had also circulated information from the chief medical officer from two weeks earlier, about the spread of Covid-19 corona virus.

Staff had regular one to one meetings and appraisals with the manager and described being able to raise concerns. The pharmacy had a small, close-knit team and staff also felt able to raise concerns with the regular pharmacists if they needed to. The dispenser described how she had taken the initiative to download electronic prescriptions regularly. She did an additional download every lunchtime to check for any acute prescriptions. She did this so that the prescriptions could be dispensed ready for people when they came in to collect them.

The ACT described being able to raise concerns. She was keen to review the team's daily workload and agree the prioritisation of tasks with her colleagues. She felt it was important to work together to complete high priority tasks as well as routine tasks such as date checking. The RP was able to make her own professional decisions in the interest of patients and felt able to manage targets as part of the daily workload. She said she would offer an MUR to patients who needed them. She prioritised MURs for higher risk groups such as those on anti-coagulant medicines, NSAIDS, antidiabetics and those on cardiovascular drugs

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are generally clean, organised and professional looking. They provide a safe, secure environment for people to receive healthcare services. The pharmacy uses its facilities in a way which protects people’s privacy, dignity and confidentiality.

Inspector's evidence

In general, the pharmacy was well lit and bright. It had a double front with full height windows, and a glass door to provide natural light. The pharmacy had a traditional layout with customer areas and the pharmacy counter to the side wall and the dispensary alongside. Aisles were kept clear of obstructions and were wide enough for wheelchair users. There was a small seating area for waiting customers. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The dispensary was compact. It had a three to four metre run of work bench at its prescription reception area next to the counter. This extended into a further six to seven metre L- shaped run of work bench to the far end which was largely sealed off from customers. The area of dispensing bench to the front had three work stations. With shelving and drawer units behind for storing medicines. The dispensing bench to the front was where most of the dispensing took place. The majority of accuracy checking took place in the quieter area to the rear. The pharmacy had segregated an area in the stock room upstairs for multi-compartment compliance pack dispensing. Packs dispensed here were brought down to the dispensary and placed on dedicated shelves to await a check. Once checked they were placed in dedicated storage areas while awaiting delivery. Completed prescriptions were stored in drawers where they could not be viewed by the public. Work surfaces were well used but there was a clear work flow. Access to the dispensary was authorised by the pharmacist.

The pharmacy had a consultation room unit in the back-shop area which the pharmacist used for private consultations and services such as flu vaccinations. Customers using the room would be escorted through a door, generally only used by staff, and taken a short walk through the warehouse area to where the room was located. Passing staff notices and work schedules on the walls. The Pharmacy’s back shop and upstairs areas were spacious whereas the main dispensary was relatively cramped. In general, the pharmacy was tidy and organised and had a professional appearance. Shelves, work surfaces, floors and sinks were generally clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. And, people can easily access them. The pharmacy generally sources, stores and manages medicines safely. And it carries out checks to make sure its medicines are fit for purpose. Staff try to make sure they give people the advice and information they need to help them use their medicines safely and properly.

Inspector's evidence

Posters on the pharmacy window promoted seasonal services such as winter health and flu vaccinations. And there was a range of information leaflets available for customer selection in the consultation room. And in the healthy living display near the waiting area. A selection of services was also advertised on the wall in the HLP area. Current health messages on the HLP board include antibiotic awareness, cancer awareness and the NHS 'help us to help you' message. The pharmacy also had a large poster promoting diabetes awareness. The pharmacy had step-free access from outside and an automatic door. Aisles were wide and kept clear of obstructions. And were wide enough for wheelchair users to move around. The consultation room was of a size suitable for wheelchair access. The pharmacy offered a prescription collection service and a prescription ordering service for those who needed help to manage their prescriptions.

There was an up-to-date set of SOPs in place. In general, staff appeared to be following the SOPs. A CD stock balance was carried out every week as per the SOP. And the quantity of stock checked (Oxycontin 10mg) matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. And patient information leaflets (PILs) were offered to patients with each supply. The medication in compliance packs was given a description, including colour and shape, to help people to identify their medicines. This also helped people to identify and remove tablets such as soluble aspirin which needed to be dissolved in water before administration. The labelling directions on compliance aids referred patients to the PIL and gave the required BNF advisory information to help people take their medicines properly. Staff were aware of the need to counsel patients, in the at-risk group, taking sodium valproate. Although they did not currently have any patients in the at-risk group taking the medication, they had the warning cards, to help them provide the appropriate information if needed. All packs of sodium valproate in stock bore the updated warning label. And the pharmacy had additional warning labels if needed.

Medicines and Medical equipment were obtained from established wholesalers; NWOS, Alliance Healthcare, Phoenix and AAH. Unlicensed 'specials' were obtained from BCM specials and IPS. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and two fridges were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Stock was regularly date checked and records kept. The team were not yet scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD) requirements. Staff stored diabetic medicines and other high-risk drugs such as methotrexate and quetiapine, separately, in a separate drawer. This was done to draw the attention of staff and prompt additional checks.

Waste medicines were disposed of in the appropriate containers and collected by a licensed waste contractor. Staff had a list of hazardous waste on the wall to refer to, for easy reference. The list was

available to help ensure that all medicines were disposed of appropriately. The pharmacy had a separate container and separate disposal arrangements for cytotoxic medicines. Drug recalls and safety alerts were acted upon promptly. Records were kept for recalls of items which the pharmacy stocked. Stocks of Ibuprofen 400mg tablets recalled on 20 February 2020, had been identified and quarantined for return. The pharmacy had not had any of the Atrolak XL brand of quetiapine PR tablets, which had been recalled on 21 February 2020.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured into place in accordance with regulatory requirements. The pharmacy had the measures, tablet and capsule counting equipment it needed. Methadone measures were marked in red and stored separately. A note explaining the colour coding had been displayed next to the measures. Measures and tablet triangles were of the appropriate BS standard and generally clean. Precautions were taken to help prevent cross contamination by using cytotoxic tablets in foil strips. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to a range of up-to-date information sources such as hard copies and the on-line BNF and BNF for children. They also used the drug tariff, and medicines complete which provided access to Stockley, Martindale, EMC and NICE. The pharmacist also had the BNF app on her phone.

The pharmacy had five computer terminals available for use. Three were in the dispensary, one in the compliance pack dispensing room and one in the consultation room. All computers had a patient medication record (PMR) facility, were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected for safe disposal. Staff generally used their own smart cards when working on PMRs although dispensing staff were using each other's. Staff generally used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure.

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.