General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5-7 Bell Street, HENLEY-ON-THAMES, Oxfordshire, RG9 2BA

Pharmacy reference: 1035922

Type of pharmacy: Community

Date of inspection: 28/06/2022

Pharmacy context

The pharmacy is located on a busy high street with other businesses in Henley-on-Thames in Oxfordshire. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include new medicines service, hypertension case-finding service, community pharmacist consultation service (CPCS), substance misuse and seasonal flu vaccinations.

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	1.1	Good practice	The pharmacy team members make sure they identify and manage the risks in providing services to protect the safety of people who use the pharmacy.
		1.2	Good practice	The pharmacy team members review the pharmacy's services all the time to identify risks and take action to improve people's safety.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages and supports its team members to keep their skills and knowledge up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Members of the team make sure people taking high risk medicines are identified and get all the information they need to use their medicines safely.
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. It provides its team members with clearly written instructions to help them identify risks and work safely. Members of the team record their mistakes so that they can learn from them and stop the same mistakes happening again. The pharmacy keeps its records up to date and these show it is providing safe services. Its team members protect people's private information. They are trained in how to safeguard the welfare of vulnerable people. The pharmacy has arrangements in place so it can still dispense medicines in an emergency.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes and reviewed them regularly to spot patterns or trends in the types of mistakes they made. They discussed the mistakes they made to learn from them and take action to reduce the chances of them happening again The team explained that medicines involved in incidents, or were similar in some way, such as amlodipine and amitriptyline, were generally separated from each other in the dispensary. And were highlighted by shelf-edge labels alerting team members to take care when picking medicines. The pharmacy displayed posters to help the team manage their time and complete tasks effectively. The pharmacy's head office produced a monthly bulletin of patient safety information which the pharmacy team members read and signed.

Members of the pharmacy team responsible for making up people's prescriptions used tubs to separate each person's medication and to help prioritise their workload. They referred to the prescription when picking products and attaching labels. And they referred to a pharmacist's information form (PIF) which was completed for each person's prescription. The pharmacist considered information on the PIF when checking the prescription such as allergies, drug interactions, supply of high-risk medicines and outstanding medication. The pharmacy team added colour-coded laminated cards to highlight prescriptions with high-risk medicines such as those requiring therapeutic monitoring or counselling by the pharmacist. Assembled prescriptions were not handed out until they were clinically, and accuracy checked by the pharmacist. Team members initialled dispensing labels to identify who dispensed and checked the medicines. As part of the clinical check the pharmacist checked interactions between medicines prescribed for the same person and any interventions were recorded on the patient medication record (PMR). Prescriptions were endorsed and initialled by the team members to show who entered data, dispensed, checked and handed out the medicines to people. In the event of a systems failure, the pharmacy had a business continuity procedure to follow to ensure people were supplied their medicines. A sign would be displayed at the entrance and team members would ask people to call back.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last inspection. Members of the pharmacy team accessed SOPs relevant to their role which they read and were tested on to show they understood them and would follow them. The pharmacy's head office monitored completed training in the SOPs to make sure all the team worked safely and effectively. The pharmacy displayed a notice that told people who the responsible

pharmacist (RP) was. And it kept a record to show which pharmacist was the RP and when along with the fridge temperature records and a controlled drug (CD) key log. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And why they would refer repeated requests for the same or similar medicines, such as medicines liable to misuse, to a pharmacist.

The pharmacy had a complaints procedure. It reported concerns on the pharmacy incident and event reporting system which had different options depending on the nature of the concern. People were able to provide feedback on how the pharmacy could improve its services via 'How did we do?' cards distributed by the pharmacy team or online. The practice leaflet was available and included details about how to complain and what services were accessible.

The pharmacy had risk-assessed the impact of COVID-19 on its services and the people who used the pharmacy. The pharmacy's team members were self-testing for COVID-19 regularly. To protect against infection, the pharmacy had screens at its counters and hand gel for people to apply. Some of the pharmacy team wore type 11R face masks. The pharmacy monitored the safety and quality of its services. For instance, it conducted a health and safety audit which included some pharmacy systems. And it undertook clinical audits such as weight management, inhaler technique and anti-coagulant medicines in line with the pharmacy quality scheme.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had controlled drug (CD) and methadone registers, and its team kept the entries up to date. And checked the stock levels recorded in the registers weekly in line with the SOP. A random check of the actual stock of one CD matched the recorded amount. The pharmacy kept records for the supplies of unlicensed medicinal products it made. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically. It received private prescriptions from Boots online service. The records were generally complete.

The pharmacy was registered with the Information Commissioner's Office. Its team members completed regular training in procedures to protect people's private information. They made sure computer screens couldn't be seen by other people and confidential wastepaper was collected and disposed of securely. Team members used their own NHS smartcards. The pharmacy had a safeguarding policy and the team had completed a safeguarding training course. Members of the pharmacy team knew what to do and who to contact if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to provide its services safely. They work effectively together to manage the workload. And they are encouraged to keep their skills and knowledge up to date through ongoing learning. Team members are comfortable about making suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist, one part-time pharmacist one day each week so there was double pharmacist cover, three full-time pharmacy advisors (PA) and three part-time PAs qualified or in training. PAs were trained and qualified to dispense prescriptions and sell medicines over the counter (OTC). The pharmacy's delivery persons were shared with other branches. The pharmacy team members covered the weekend opening hours. Locum and relief pharmacists provided cover when needed.

The pharmacy team members had their own training profiles on 'myHub' which they could access through their mobile phones. A member of the team demonstrated their profile with completed modules on the pharmacy computer. People in training were allocated protected learning time depending on the workload. Training included SOPs, topics such as risk assessment in line with the pharmacy quality scheme and training packs linked to the sales plan. So recent training included treating hay fever. The pharmacy's head office monitored completed eLearning topics so the pharmacy team were able to provide services safely. Team members could access Centre for Post-graduate Pharmacist Education (CPPE) training.

Members of the team worked well together. So, people were served quickly, and their prescriptions were processed safely. The pharmacist supervised and oversaw the supply of medicines and advice given by the pharmacy team. A PA explained the OTC sales protocol they needed to follow when people wanted to purchase a medicine. And the PA knew when to refer requests to a pharmacist. Depending on their role, team members had an appraisal at different intervals to monitor performance and identify training needs. And some feedback was given 'on the spot'. The pharmacy team had regular 'huddles' to discuss service updates and they communicated on paper or via a WhatsApp group. The pharmacy had a policy which all its team members could access to provide feedback. And a member of the team described the team, as a whole, having an open relationship, so they had been able to discuss and improve the management of the flu vaccination service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright, clean and suitable for the provision of healthcare. Its consultation room is signposted, and people can have a private conversation there with a member of the team. The pharmacy is secured when it is closed to protect people’s private information and keep the pharmacy’s medicines safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And the pharmacy had taken steps to make sure it and the team didn’t get too hot. The pharmacy had a medicines counter, leading to the dispensary. A team member prepared multi-compartment compliance aids in a separate room. The hatch between the dispensary and the public area was not in use at the time of the visit for clients to attend for the supervised consumption service. The pharmacy had a consultation room which was signposted and locked when not in use. It protected people’s privacy and people wanting to have a private conversation with a team member were signposted to the consultation room. There were posters explaining how to deal with needlestick injury and fainting and the team knew the location of the nearest defibrillator. The pharmacy had a health information display. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. And records were maintained of cleaning routines.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can easily access the pharmacy's services. Its working practices are safe and effective. It obtains its medicines from reputable sources to protect people from harm. The pharmacy team members make sure they store them securely at the right temperature. They keep records of regular checks to show medicines are fit for purpose and safe to use. And they know what to do if any medicines or devices need to be returned to the suppliers. Members of the team sign an audit trail so they can identify who dispensed and checked prescriptions. And they highlight prescriptions with high-risk medicines and make sure people get the information they need to use their medicines safely.

Inspector's evidence

The pharmacy had a wide entrance with automated doors. And its entrance was level with the outside pavement. This made it easier for someone who used a wheelchair, to enter the building. The pharmacy team members tried to make sure people could use the pharmacy's services. So, they were able to print large font labels for people who were visually impaired and there was a hearing loop to help people with difficulty hearing. The pharmacy had seating for people to use if they wanted to wait. It was set away from the counter to help people keep apart. Members of the pharmacy team were helpful. And they signposted people to other local providers if a service wasn't available at the pharmacy. The pharmacy provided the community pharmacist consultation service (CPCS) dealing with NHS referrals to treat minor ailments and make emergency supplies of medicines. And there were more referrals at the weekend. The pharmacy team could offer the blood pressure monitoring service to people who had not already been diagnosed with elevated blood pressure. The pharmacists provided the new medicine service (NMS) to people to help them take their new medicines in the best way. They followed up the first conversation at set intervals by phone to discuss and resolve any problems such as side effects that might have previously resulted in the person not taking their new medication.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It texted people in advance of delivering to make sure they were at home, and it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy supplied medicines in multi-compartment compliance aids for people who found it difficult managing their medicines. The pharmacy followed a timetable to ensure the compliance packs were prepared and supplied on time. They managed re-ordering of prescriptions and the doctors' surgeries sent the prescriptions electronically to the pharmacy. A pharmacy team member screened new prescriptions for changes and a PIF was completed. The pharmacist clinically and final checked the prescriptions. The pharmacy team members checked whether a medicine was suitable to be re-packaged and provided a brief description of each medicine contained within the compliance packs. And they provided patient information leaflets, so people had all the information they needed to take their medicines safely.

Members of the pharmacy team knew which of them prepared a prescription by checking the initials forming the audit trail on the prescription and dispensing labels. They included colour-coded laminated cards with prescriptions to highlight high-risk medication and that a pharmacist needed to speak to the

person about the medication they were collecting. There was a procedure for dealing with outstanding medicines. The team members were aware of the valproate pregnancy prevention programme. And a pharmacist explained that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had valproate information leaflets to give to people. The pharmacy team members were trained to give out prescriptions and check and record therapeutic monitoring values. For instance, the laminated card for supplying warfarin had questions on the back to ask the person collecting the warfarin. A member of the team explained where the blood test details were recorded on the PMR.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in the original manufacturer's packaging. The pharmacy team members dispensed and checked prescriptions at designated areas. They cleared the dispensary benches as they bagged completed prescriptions and stored them in the retrieval system awaiting collection. Delivery prescriptions were kept together and separate from other prescriptions. Members of the team checked the expiry dates of medicines on a rolling weekly basis. In a random check no date-expired medicines were found. The pharmacy stored its stock, which needed to be refrigerated and kept records to show the temperature was between two and eight degrees Celsius. And it stored its CDs, securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And a team member demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

To help reduce the risk of COVID infection, the pharmacy had a plastic screen on its counter and hand sanitiser for people to apply if they wanted to. It had personal protective equipment if its team members needed to use it. The pharmacy had an SOP for blood pressure monitoring which included maintaining the equipment and emailing a referral to the doctor if appropriate. The pharmacy had a few glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had two fridges to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of the refrigerator. The pharmacy collected confidential wastepaper for safe disposal. The pharmacy team members restricted access to the pharmacy's computers and PMR system. So, only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members used their own NHS smartcards when they were working.

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.