General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7-8 Market Place, WALLINGFORD, Oxfordshire, OX10 0EG

Pharmacy reference: 1035989

Type of pharmacy: Community

Date of inspection: 23/06/2022

Pharmacy context

The pharmacy is located in a busy marketplace near other businesses and residential areas in Wallingford in Oxfordshire. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines for care and nursing homes. 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 actively manage the risks in providing services to safeguard the safety and wellbeing of people who use the pharmacy.
		1.2	Good practice	The pharmacy team continually reviews the pharmacy's systems and procedures to identify learning points and make improvements so its services remain safe.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides its team members with regular training to support and encourage ongoing learning and development.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy team members pro-actively highlight prescriptions with high-risk medicines and make sure people use these 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. Its team members follow clearly written instructions to help identify and manage risks and work safely. The pharmacy has business continuity arrangements in place so it can still dispense medicines in an emergency. Members of the team record their mistakes so that they can learn from them and stop the same mistakes happening again. The pharmacy keeps the records it needs to so it can show that medicines are supplied safely and legally. The pharmacy team members protect people's privacy and understand how they can safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes on the pharmacy incident and event reporting system. The pharmacist reviewed them regularly to spot patterns or trends to learn from and reduce the chances of the same mistake happening again. A team member explained that medicines involved in incidents, or were similar in some way, such as amitriptyline and amlodipine tablets, were generally separated from each other in the dispensary. And there were shelf-edge alert cards to highlight pairs of similar medicines. 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 them prioritise their workload. They referred to a pharmacist's information form (PIF) which was completed for each person's prescription. And it alerted the pharmacist to consider information when checking the prescription such as allergies, 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. Team members referred to the prescription when labelling and picking products. They scanned each pack of medication and the pharmacy computer system alerted them to packs of medicine which had been selected incorrectly. They initialled dispensing labels to identify who dispensed and checked the medicines.

Each prescription was endorsed and initialled by the team members who entered data, dispensed, checked and handed out the medicines to people. Assembled prescriptions were not handed out until they were clinically, and accuracy checked by a pharmacist. 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). The pharmacy team had some prescriptions dispensed off-site with the person's consent to help manage their workload. There was an SOP for screening suitable repeat prescriptions to be dispensed off-site, checked and bagged and returned to this branch for the person to collect. To deal with an emergency and continue to provide dispensing services, the pharmacy kept a supply of printed labels, medication administration record (MAR) charts, British National Formulary warning labels and SOPs in a folder.

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 had to read and complete a test to show they understood them and would follow them. The pharmacy's head office monitored training completed in the SOPs. 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. 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 within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, 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 cards distributed by the pharmacy team or online.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. The pharmacy's team members were self-testing for COVID-19 regularly. To protect against infection, the pharmacy had a cleaning station with cleaning products, screens at its counters and hand gel for people to apply. The pharmacy monitored the safety and quality of its services. For instance, team members were observed and given feedback on how they followed the sales protocol. The team also undertook clinical audits such as weight management, inhaler technique and anti-coagulants 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 the 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 pharmacy was registered with the Information Commissioner's Office. Its team had undertaken information governance training and tried to make sure people's personal information couldn't be seen by other people and was disposed of securely. Members of the team used their own NHS smartcards. The pharmacy had a safeguarding SOP. And the team had completed a safeguarding training course. One of team described identifying and raising a possible safeguarding concern. Members of the pharmacy team knew what to do or who they would make aware 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 deliver its services. Team members work well together and manage the workload safely. They are supported in keeping their skills and knowledge up to date and are actively encouraged to undertake ongoing learning relevant to their roles.

Inspector's evidence

The pharmacy team consisted of the two pharmacists who covered three and four day shifts between them each week, one full-time accuracy checking technician (ACT), six full-time pharmacy advisors (PA) and five part-time PAs which included a trainee PA and one newly recruited person. PAs were trained and qualified to dispense and sell medicines over the counter (OTC). The ACT was the primary care network (PCN) person who liaised with other local pharmacies on behalf of the local pharmaceutical committee (LPC) regarding NHS services such as blood pressure monitoring. A delivery person was shared with other branches. The pharmacy team members covered each other's absences. Locum and relief pharmacists provided cover when needed. The pharmacy was recruiting a pharmacist to share with other local branches and who would visit care and nursing homes to train staff and monitor the pharmacy's care home services.

The pharmacy team members had their own training profiles on 'myHub' and they could access training topics such as SOPs relevant to their role. The pharmacy's head office asked the teams to complete eLearning which was either process based, or pharmacy and medicines based. Some topics were mandatory and had to be completed. Team members could access Centre for Post-graduate Pharmacist Education (CPPE) training. And they generally studied in their own time.

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. The pharmacy had an OTC sales procedure which its team needed to follow when people asked for a specific medicine. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. The pharmacy team were observed on this and other procedures and given feedback on how they followed the procedure. The pharmacy's head office also provided training materials which were linked to the company's sales plan.

Team members had an annual appraisal to monitor performance and identify training needs. They had regular team meetings to discuss updates in services and they communicated via WhatsApp groups. The pharmacy had a policy which all its team members could access to provide feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright, clean and suitable for the provision of healthcare. 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 steps were taken to make sure the pharmacy and its team didn’t get too hot. The pharmacy had been re-fitted since the last visit and it had a medicines counter, a more spacious dispensary and a large separate room to dispense care and nursing home prescriptions. There was a hatch between the dispensary and the public area where clients could attend for the supervised consumption service. The pharmacy had a consultation room which was locked when not in use and it protected people’s privacy. There were posters explaining how to deal with needlestick injury and fainting and the ACT knew the location of the nearest defibrillator. People wanting to have a private conversation with a team member were signposted to the consultation room. The pharmacy had a health information display about summer health and domestic abuse. Some items were stored on the floor in the dispensary in tote boxes. But the medicines stock was being re-arranged to free up space and available storage. 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

The pharmacy tries to make its services easily accessible to people with a range of needs. The pharmacy's working practices are safe and effective. It obtains its medicines from reputable sources and stores them securely at the right temperature. Members of the team keep records of regular checks to show medicines are fit for purpose and safe to use. They know what to do if any medicines or devices need to be returned to the suppliers. Pharmacy team members pro-actively 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 another provider if a service wasn't available at the pharmacy. The pharmacy provided the community pharmacist consultation service (CPCS) dealing with 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 offered 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 or side effects that might result 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 two hours before delivering to make sure they were at home. It kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy had recently stopped its Medisure service supplying medicines in multi-compartment compliance packs to people who found it difficult managing their medicines. But the pharmacy still supplied medicines to care and nursing home patients. The pharmacy team supplied medicines in their original manufacturer's packaging. The staff at the homes ordered the repeat prescriptions. The doctors' surgeries sent prescriptions electronically to the pharmacy where they were screened for changes and medication administration record (MAR) charts were prepared. The pharmacy team completed a form for missing items and changes which was sent to the home to resolve any queries. The pharmacist then clinically checked the prescriptions, and the pharmacy placed an order for the stock. The PAs labelled and assembled the medicines for the ACT to accuracy check before bagging for delivery. 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.

Members of the pharmacy team 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 medication. The team members were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. The PAs 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 reverse to ask the person collecting the warfarin. A member of the team was able to demonstrate 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 within their original manufacturer's packaging. The pharmacy team were able to keep the dispensary benches clear as they completed prescriptions. They 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

The pharmacy had a plastic screen on its counter. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had glass measures for use with liquids, and some were marked for use only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy had refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerators. The pharmacy collected confidential wastepaper for safe disposal. The pharmacy restricted access to its computers and patient medication record system. And 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 made sure they 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.