General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 14-16 Devonshire Road, BEXHILL-ON-SEA, East Sussex, TN40 1AU

Pharmacy reference: 1036090

Type of pharmacy: Community

Date of inspection: 27/03/2024

Pharmacy context

This is a community pharmacy in a parade of shops in a seaside town on the South Coast of England. It offers NHS services such as dispensing prescriptions, the Pharmacy First service, and the New Medicine Service. It supplies medicines in multi-compartment compliance packs to some people who need this additional support. And it delivers medicines to some people's homes. A local branch has closed within the last month, and this pharmacy has taken on additional workload as a consequence.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy records any dispensing mistakes, and it regularly undertakes documented reviews of them to help identify any actions it can take to make its services safer.
2. Staff	Standards met	2.2	Good practice	Team members receive structured ongoing training, and they get protected time at work to complete it. This helps keep their knowledge and skills up to date.
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

Overall, the pharmacy appropriately identifies and manages the risks associated with its services. Team members record and regularly review any dispensing mistakes to identify what action they need to take to help make the pharmacy's services safer. The pharmacy generally keeps the records it needs to by law and on the whole, it protects people's information well. People using the pharmacy can provide feedback about the pharmacy's services. Team members know how to protect the welfare of vulnerable people and receive regular training about it.

Inspector's evidence

There were standard operating procedures (SOPs) which were available to team members on the pharmacy computers and via a mobile app. Team members had read the SOPs, and the store manager explained that she monitored this and that staff also had to undertake tests about the SOPs to test their understanding. New SOPs were released by the pharmacy's head office periodically.

Dispensing mistakes which were identified as part of the final check before the medicine was handed to a person (near misses) were recorded. A team member described how they discussed when medicines changed brand in the team meetings, to help prevent picking mistakes. Dispensing errors, where a mistake had been made and the medicine handed out, were recorded on the pharmacy computer. The store manager described how any near misses and dispensing errors were reviewed monthly, and the outcomes of the reviews were documented and shared with the team. She explained that medicines were now scanned into the computer as they were dispensed, which had reduced the number of near misses. She said that most near misses recently had been where the wrong quantity had been dispensed, and this had been discussed within the team and staff were reminded to double check the quantities. Other actions had been taken to help prevent a recurrence of these mistakes, such as reminding staff to mark any split packs. And the two different pack sizes of amoxicillin and indapamide had been separated on the shelves. The store manager was in the process of training one of the pharmacy technicians to undertake the monthly reviews and was able to show documented reviews from earlier in the year. The team responsible for preparing multi-compartment compliance packs for people and care homes kept separate records about near misses which fed into the main review.

Team members could describe their roles and responsibilities. A dispenser could explain what they could and could not do if a pharmacist had not turned up in the morning.

Cards were available at the front counter which informed people how they could provide feedback or raise concerns. People could also give feedback by other ways such as in person, online, or via the customer service number. There was a complaint procedure for staff to follow.

Indemnity insurance was arranged by head office. The right responsible pharmacist (RP) notice was displayed, and the RP records seen largely had the required information recorded. Some records about private prescriptions dispensed did not give the prescriber's details, and records about emergency supplies mostly had the nature of the emergency recorded. Several records about unlicensed medicines supplied did not contain the required information. Team members thought that this information might be recorded elsewhere but were unable to locate the records during the inspection. The store manager said that she would ensure the required information was recorded in the future. Controlled drug (CD)

registers seen had the required information recorded and the CD running balances were checked regularly. A random check of a CD found that the amount in stock matched the recorded balance.

No confidential information was readable from the public area. Confidential waste was placed into designated sacks and sent offsite for secure disposal. Two of the general waste bins seen each had a label containing confidential information in them; the labels were immediately removed. The confidential waste and general waste bins were kept next to each other, which may make it more likely that the contents transfer if the bins are full. Trained team members had smartcards to access the electronic NHS systems. The regular pharmacist's smartcard was in the computer at the start of the inspection, and the card was removed when this was highlighted.

The store manager explained that safeguarding and confidentiality were mandatory training course and confirmed that all team members had completed them. The RP confirmed that he had done safeguarding training and with some prompting, could describe what he would do if he had a concern about a vulnerable person, and he was made aware of the NHS safeguarding app.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is busy and staff are struggling at times, particularly as some team members are on annual leave, but it has just enough team members to provide its services safely. The pharmacy is in the process of attempting to recruit more staff. Team members do the right training for their roles, and they get protected time to do ongoing learning to help keep their knowledge and skills up to date. They have regular meetings and feel comfortable about raising any concerns.

Inspector's evidence

In the dispensary during the inspection there was the store manager, a pharmacy technician, a trained dispenser, a trainee dispenser, the RP (a locum pharmacist), and a trained medicines counter assistant (MCA). The store manager was a trained dispenser but was not currently involved in the dispensing process. There was also a new member of staff who had started a couple of days ago and was shadowing another member of the team. In the multi-compartment compliance packs rooms upstairs, there was an accuracy checking technician (ACT) and three trained dispensers. The inspection took place in the week leading up to the Easter holiday, and the pharmacy was busy with long queues at times. The team was around a week behind on repeat medication dispensing but was generally able to dispense medicines for people who came in with prescriptions. Two team members were on annual leave. The store manager said that she was currently trying to recruit two more team members, although this had been hard to do. She said that all staff were in the following week, and this should enable the team to catch up.

Team members got protected training time at work to complete any ongoing training, and their progress was monitored by the store manager and head office. They usually completed ongoing training online, and this included mandatory training such as safeguarding and new SOPs. The pharmacy received a monthly magazine from head office which included updates and learnings from any incidents. An all-staff meeting was held every Tuesday, and team members felt comfortable about raising any concerns or making suggestions. Team members received regular appraisals. The ACT was aware of the continuing professional development requirements and said that she had recently completed training about sepsis. Team members were set some targets to achieve but did not feel that these adversely affected people's care or professional decision making.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and are generally kept clean and tidy. People can have a conversation with a team member in a private area. And the premises are kept secure from unauthorised access.

Inspector's evidence

The pharmacy was generally clean and tidy, with good lighting throughout. Some workspaces were a little cluttered with baskets of dispensed items, but there was enough space to dispense safely. The ambient temperature was suitable for the storage of medicines. The dispensary generally had enough space, but there were some points which made it harder for team members to move past each other if there were several of them in the dispensary. The premises were secure from unauthorised access and access to the back shop area was restricted. The rooms upstairs used to prepare multi-compartment compliance packs were spacious and clean and tidy, and they were kept secure. There was a consultation room next to the dispensary, which provided an adequate level of soundproofing. The room was tidy and mostly clean, although there was some dust buildup on the extractor fan grille.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services in a safe way, and people with a range of needs can access them. Team members highlight prescriptions for higher-risk medicines so that there is an opportunity to provide additional information to people taking these medicines. The pharmacy gets its stock from reputable suppliers and generally stores it appropriately.

Inspector's evidence

There was step-free access from the street via an automatic door. The store was set over two floors, and there was a customer lift. There was enough space on the shop floor to help people with wheelchairs and pushchairs manoeuvre. The pharmacy computers could generate large-print labels when required, and there was a hearing loop. The pharmacy delivered medicines to some people's homes.

The pharmacy provided the Pharmacy First service but was not providing it on the day of the inspection as the regular pharmacist was off. The store manager said that the pharmacy had made supplies under the service to around six or seven people so far and people were usually referred by GP surgeries. A team member said that many people who came in for the service did not fit into the criteria. The store manager said that they were planning to reach out to local surgeries to provide information about the service. She said that the regular pharmacist was able to provide the service while managing the pharmacy's workload.

The technician showed how laminated cards were used to highlight prescriptions for higher-risk medicines such as valproate, warfarin, and lithium. The cards had prompts on them about counselling information to provide to people. Prescriptions for CDs were highlighted to help team members handing them out to know if the prescription was still valid. Team members were aware of the guidance about pregnancy prevention for people in the at-risk group who took valproate medicines. They had completed training about the subject and were aware of the need to supply the medicine in its original pack.

The pharmacy supplied medicines in multi-compartment compliance packs to people. The number of people it supplied the packs to had increased significantly, as when the other branch had closed, it had taken over supplying these packs to people from the other branch. A team member explained how this had caused some challenges, as batches of people had been transferred each week and it had not been clear when people's pack cycles were due. But team members had managed, and the store manager confirmed that no people had gone without their medication. Packs seen were labelled with an audit trail of who had dispensed and checked them, and a description of the tablets or capsules inside. Patient information leaflets were routinely supplied. The pharmacy also supplied medicines in original packs to some care homes and provided administration charts.

The pharmacy received some medicines which were dispensed by the company's hub pharmacy. The dispenser explained how the system worked, and the medicines were scanned as part of the process. Team members said that any uncollected dispensed items were checked and taken off regularly and prescriptions sent back to the spine.

The pharmacy obtained its medicines from licensed wholesale dealers and specials suppliers and generally stored them in a tidy way. One medicine on the shelf had been put into a white box which was not labelled with a batch number, and this was immediately removed. Bulk liquids were mostly marked with the date of opening. Team members date-checked the stock periodically, but they were a little behind on the most recent checks. The trainee dispenser explained that to help mitigate the risks with this, an additional check about the expiry date was made when medicines were dispensed. A check of random medicines in the dispensary did not find any which were past their expiry date. CDs were kept secure. The pharmacy had three fridges, and the temperatures were monitored and recorded daily. Medicines for destruction were appropriately separated from current stock.

The pharmacy received drug alerts and recalls electronically, and team members were alerted when any were received. Records were kept about the action the team members had taken in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. It uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

There was a range of clean glass measures, and some were marked for use with only certain liquids. Tablet counting triangles were clean. The store manager said that there were separate triangles for use with cytotoxic medicines, but these were rarely used. The pharmacy technician confirmed that the blood pressure monitor had been recently calibrated, and there was a new otoscope available for the Pharmacy First service. Team members explained that the pharmacy's equipment had been tested for electrical safety, with the exception of the printers which were new and did not require a check yet.

Computer terminal screens were turned away from people using the pharmacy to help protect people's information. And the phone was cordless so it could be moved to a quieter place in 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.