

Registered pharmacy inspection report

Pharmacy Name: Boots, 23-25 Vicarage Field, HAILSHAM, East Sussex, BN27 1BG

Pharmacy reference: 1036200

Type of pharmacy: Community

Date of inspection: 20/06/2022

Pharmacy context

This pharmacy is in a small shopping precinct in the centre of Hailsham, near Eastbourne in East Sussex. It dispenses people's prescriptions, sells over-the-counter medicines and gives health advice. It also delivers some medicines to people who can't easily get to the pharmacy themselves.

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 provides its services in line with clear, up-to-date processes and procedures which are being followed by its team members. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps satisfactory records of the mistakes that happen during the dispensing process. And it makes sure its team members learn from their mistakes, so they are less likely to happen again. The pharmacy manages and protects confidential information well and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has adequate insurance in place to help protect people if things do go wrong.

Inspector's evidence

There were Standard Operating Procedures (SOPs) in place to underpin all professional standards, signed and read by staff. Several had been updated in November 2021 and due a review in November 2022 with others, notably the SOPs for controlled drugs (CDs) dated Nov 2021 and due to be reviewed in Nov 2023. The responsible pharmacist (RP) SOP training log had been signed by staff in Jan 21. Staff roles and responsibilities were all set out in a matrix within the SOP folder, and staff were all clear on the correct procedures to follow. Those questioned could demonstrate that they knew what they could and couldn't do, and when to ask for help.

There was a file containing risk assessments carried out by pharmacy staff to help make sure that the pharmacy was a safe place to work, and that its services were being provided safely. Those examined appeared to be in order. Errors and near misses were seen to be regularly recorded on a 'Near Miss Incident log' kept in the dispensary by the pharmacist's workstation. One of the pharmacy advisors was also the 'patient safety champion.' She reviewed the near misses with the RP and completed the 'Patient Safety Review' (PSR) every month for head office. A copy of the most recent review was available for all staff to read. The RP also gave team members 'on the spot feedback' when they made errors so that they could learn from them straight away. Both the RP and one of the pharmacy advisors confirmed that since they had introduced the Columbus patient medication record (PMR) system they had seen a reduction in selection errors. The main errors they now saw related to quantities and items without a recognisable barcode. These items were flagged to the pharmacist on the pharmacist information form (PIF) so that they would know that they had not been successfully scanned and therefore needed an extra check. They still highlighted the 'Look Alike Sound Alike' (LASA) drugs which were automatically printed on the digital PIF to help avoid picking errors. They did this because they were no longer following the previous 'select and speak' process and all reminder labels had been removed from the shelves. They made sure that every box was scanned so that the PMR system could highlight incorrect or unknown barcodes.

There was a business continuity plan in a red bag upstairs for staff to easily find, and the RP knew who to contact for advice in the event of an emergency. People working in the pharmacy were able to clearly explain what they do, what they were responsible for and when they might seek help. The RP record was seen to be complete and up to date. The RP explained the process for completing an 'advance declaration' in the RP record. She had to do this on two days a week when staff started work at 7am. Staff were able to describe what action they would take in the absence of the responsible

pharmacist, and they explained what they could and could not do. The responsible pharmacist notice was correct and clearly displayed for patients to see.

The Community Pharmacy Patient Questionnaire (CPPQ) had not been carried out for two years because of the pandemic. But the pharmacy did seek feedback online from people who used its services. The credit card style prompt cards normally used for seeking feedback were not available at the time of the inspection, but the RP was going to order some more. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display by the consultation room. It included contact details for the company's head office, Patient Advice and Liaison Service (PALS) and the Independent Complaint Advocacy Service. A certificate of professional indemnity and public liability insurance from XL Insurance Co. Ltd was held electronically on the company's intranet.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and those inspected were complete with most of the necessary details correctly recorded. One of those examined recorded the person's usual GP instead of the actual prescriber. The RP corrected the record and would brief the rest of the team. There were no Emergency supply records as the RP usually signposted people to their GP or NHS 111 for a prescription.

The controlled drug (CD) register was seen to be correctly maintained, with wholesaler addresses written in full. Running balances were checked weekly in accordance with the SOP. Stock balances of two random samples were checked and found to be correct. Amendments to the records were asterisked with a signed and dated footnote to identify who had made the amendment. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed 'specials' were present with all of the necessary information recorded. Access to the CD keys was recorded daily in the CD key log, stored within the pharmacy duty folder.

Staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. There was a Privacy notice on display for people to see. One of the pharmacy advisors explained that she knew not to discuss people's medicines or other personal details where other people might overhear them. Confidential waste was kept separate from general waste and shredded offsite. Completed prescriptions awaiting collection were stored in opaque trays so they were not visible to those waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies were in the safeguarding section of the pharmacy duty log. All registrants had been trained to level 2 and all other staff members had undergone level 1 Boots e-learning. Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist. All staff were dementia friends.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy usually has barely enough trained staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They work well together and can make suggestions to improve safety and workflows where appropriate. But they may not be getting the support they need to complete their work on time while new team members are still being trained.

Inspector's evidence

There were two pharmacy advisors, one trainee healthcare advisor, one medicines counter assistant still in her probationary period plus the RP on duty during the inspection. The size of the team appeared to be tight for the workload at the time of the inspection. The RP did point out that two members of staff had been recently recruited but it would take some time for them to complete their training. In the event of staff shortages, there was another member of staff available on a zero-hours contract who could be called upon to help. But this person hadn't always been available when needed. Team members expressed their concerns about being 'short staffed' and cited an example where 290 prescriptions were still unlabelled when they finished for the day. The inspector counted 207 baskets of prescriptions awaiting checking by the pharmacist, some of which dated back four working days. According to staff this had been exacerbated by the pharmacy no longer being able to send any of its prescriptions away to the company's centralised DSP in Preston, resulting in their increased workload. Those team members had expressed their concerns with the area manager and were also aware of the company's whistleblowing policy. The RP was steadily working through the baskets and was able to locate people's prescriptions when they came in to collect them. All staff wore badges showing their names and role.

Certificates to confirm staff qualifications were not examined but were available both online and in paper files to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. The RP explained how she could track the progress of each staff member's training through a report available online. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. All members of staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines.

The RP confirmed that she was comfortable with making decisions and did not feel pressurised to compromise her professional judgement. There were targets in place, but they were applied sensibly. Team members were involved in open discussions about their mistakes and learning from them.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide a secure, spacious and generally professional environment for people to receive its services. They include a suitably private room which the team uses for some of the pharmacy's services and for private conversations.

Inspector's evidence

There was step-free access into the pharmacy through automatic double doors. The premises were accessible to people with pushchairs or those with mobility issues. The pharmacy premises were clean, tidy and in a reasonable state of repair. There was a large dispensary which was well organised with separate assembly and checking areas. The workstations were kept reasonably tidy and free of clutter.

There was a small health promotion area with leaflets and posters highlighting current health priorities and available services. There was also a large poster in the window advertising the company's online doctor service. The poster was creased and had partially fallen down. There was a consultation room for confidential conversations, consultations and the provision of services. There was no confidential information on view inside the consultation room. The sharps bin was kept in a locked cupboard in the room. The door to the room was securely closed when it was not in use.

The sink in the dispensary was clean and there was hot and cold running water with handwash available. Room temperatures were appropriately maintained by combined heating and air-conditioning units, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. And it keeps appropriate records of the checks it makes and the advice it gives people.

Inspector's evidence

Controls were seen to be in place to reduce the risk of picking errors, such as scanning all barcodes and annotating the PIFs as referred to earlier. They were used to communicate messages about the patient's medicines to the pharmacist. And to highlight new medicines, changes to their medicines, any allergies or whether the person was eligible for further services, such as an MUR. The form also had a blank box to write any further information that the dispenser thought the pharmacist should be aware of, for example if the product had not been successfully scanned. There was also a selection of laminated prompt cards for specific types of prescription, for example those for babies and young children, or those for high-risk medicines such as warfarin. They prompted staff to check key safety information with the person collecting the prescription. They used baskets to keep individual prescriptions separate, and prescription labels were initialled to show who had dispensed and checked them. The system also endorsed the prescription tokens with prompts for the staff to sign showing who had labelled, clinically checked, assembled and completed the final check. Staff initialled the bag label on the finished prescriptions to complete the audit trail, signifying who had filled the bag and checked that it was complete and correctly labelled. All of this helped to identify who had been involved at each stage in the process if any query arose after the prescription had been handed out.

Owings tickets were in use when medicines could not be supplied in their entirety. The prescription was completed as soon as the missing item was back in stock. Prescriptions for CDs or fridge lines in retrieval awaiting collection were highlighted with laminated prompt cards so that staff would know that there were items to be collected from the fridge or CD cupboard. Schedule four CDs were not highlighted but the pharmacy advisor explained how the PMR system would warn staff if they scanned the bag label after its 28-day expiry. The prescription retrieval shelves were cleared every five to six weeks. Those items removed were put in a separate area and one of the dispensary team would send a reminder text to the patient. If the items weren't collected after another two weeks, the medication was returned to stock and the EPS prescription returned to the NHS spine.

Staff were aware of the risks involved in dispensing valproates to women in the at-risk group. All such people were counselled and provided with leaflets and cards highlighting the importance of having effective contraception. The pharmacy advisor confirmed that these interventions were then recorded on the PMR system. People taking warfarin were asked if they knew their current dosage, and their INR results were also recorded on the PMR system. There were laminated prompt cards to go with the PIF to ensure that staff checked, and the key points were listed on the reverse to remind them.

The pharmacy received some private prescriptions electronically from the company's online doctor service, regulated by the care quality commission (CQC). The RP stated that most of those received were for antibiotics to treat urinary tract infections. They also received some prescriptions for Saxenda, a product used to help people lose weight. The RP described how she would contact the prescriber direct if she had any concerns about these online private prescriptions. There was also a mechanism for her to flag the prescription for the prescriber's attention. She would not complete the supply until she had resolved her concerns. She also encouraged people to inform their GP about their private prescriptions.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance. Unlicensed 'specials' were obtained from Alliance Specials. Routine date checks were seen to be in place, and record sheets were seen for each quarter. Items approaching their expiry date were recorded on monthly sheets, and any left in stock one month prior to expiry were then disposed of. There were records present for items due to expire each month up to and including July 2022. Fridge temperatures were recorded daily for both fridges, and all seen to be within the correct temperature range. Pharmacy-only medicines were displayed behind the reception counter to prevent self-selection of these medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients returning sharps were signposted to the local council for disposal. There was a tray containing protective gloves to help staff safely sort through any returned medicines. The pharmacy didn't have a separate purple-lidded hazardous waste container for the disposal of medicines classified as hazardous waste. Nor did it have a list of those medicines available for staff to refer to. The RP agreed to obtain both.

The pharmacy received drug alerts and recalls from the MHRA via 'my calendar' on 'Boots Live', printed copies of which were kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has satisfactory facilities for the services it provides, and it makes sure that they are kept suitably clean. It also ensures that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy equipment and facilities were seen to be appropriate for the services provided. The consultation room was clean and tidy. There was a range of crown stamped measuring equipment, including a separate measure labelled not to be used for methadone. There were two medicines fridges, and two CD cabinets. The pharmacy had up-to-date copies of the BNF and BNF for children, as well as internet access which they used as an additional reference source.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen in use with no sharing of passwords.

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.