General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 26 Eastbourne Road, Pevensey Bay, PEVENSEY, East Sussex, BN24 6ET

Pharmacy reference: 1036252

Type of pharmacy: Community

Date of inspection: 19/07/2024

Pharmacy context

This is a small branch of Boots in a seaside town. It dispenses people's prescriptions, sells over-the-counter medicines and gives healthcare advice. It provides a range of other services such as the NHS Pharmacy First Service. It also delivers medicines to people who can't visit the pharmacy themselves.

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	1.1	Good practice	Team members complete a quiz to check their understanding of each SOP before they can sign it off as read and understood. The area manager oversees this and intervenes if necessary to ensure everyone understands and follows the SOPs.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides its team members with protected learning time which they use to keep themselves up to date. It also makes good use of expertise available in other local branches to help its own team with their training.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy makes good use of its technology to ensure that people are always offered advice to help them take their medicines safely, and to keep a record of each intervention.
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. It is good at ensuring they understand how to carry out those tasks. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps suitable records of the mistakes that happen during the dispensing process. The pharmacy team regularly reviews them so that they can learn from them and avoid problems being repeated. But they don't always record those reviews. 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 appropriate insurance in place to help protect people if things do go wrong.

Inspector's evidence

The pharmacy had up-to-date Standard Operating Procedures (SOPs) in place to help its team members carry out their tasks and underpin all professional standards. They were all online and available to each team member on their own personal device as well as the pharmacy's computers. The area manager, who was present during the inspection, demonstrated how she could see each individual team member's progress with signing off the SOPs. There was a quiz for each SOP, which had to be successfully completed before the individual team member would be signed off to carry out the task(s) associated with each SOP. The pharmacy team was currently 100% up to date on the quizzes. If a team member failed a quiz three times, then the area manager would check their understanding and provide any necessary coaching to help them. The area manager could track everyone's progress and make sure they all stayed up to date with their SOPs. The SOPs were regularly reviewed and updated centrally on a rolling two-year cycle. The pharmacy currently had a 'mission' for everyone to have read and signed off three updated SOPs relating to over-the-counter (OTC) medicines by 31 July. Staff roles and responsibilities were linked to the SOPs that had been signed off, so that they only carried out tasks they were competent to do. Those team members questioned were all clear on the correct procedures to follow.

There were risk assessments in place covering the pharmacy's activities. One example being that for the dispensing support pharmacy (DSP) in Preston that the pharmacy used for some of its prescriptions to be assembled. The risk assessment was updated every six months and the procedures were also audited.

The pharmacy had a business continuity plan, together with an emergency contact list, so staff would know who to contact in an emergency. Elements of the plan were seen in action as there was a global IT failure on the day of the inspection which resulted in the local GP practices being unable to send electronic prescriptions. The responsible pharmacist (RP) was assessing each request for prescription medicines and in most cases offering an emergency supply to cover the weekend, by which time he expected the system to be operating normally. Those supplies were correctly documented with a valid reason for each supply. In other cases the pharmacy was requesting manually signed green paper prescriptions from the surgeries.

Errors and near misses were seen to be regularly recorded on two online platforms. Near misses, which

were errors that had been identified and corrected whilst still within the pharmacy, were recorded on the Datix platform. Errors which had been identified after the medicine, or service, had been provided to people, were recorded on the PIERS platform for onward reporting centrally to the NHS 'learn from patient safety events' (LFPSE) service. These mistakes were also escalated to their area manager for them to review and take action if necessary. The entries included details of who had been involved in the mistake, what had been learned as a result and any action taken to reduce the chance of it happening again. There was a 'patient safety champion,' who reviewed them with everyone at regular monthly meetings. They also completed a 'Patient Safety Review' (PSR) every month for head office. Copies of these reviews were available on the noticeboard for all staff to read, although the most recent was for April 2024. Both the technician and the area manager confirmed that they had still been reviewing and discussing their mistakes and the records would be brought up to date.

The pharmacy carried out a number of audits and checklists to ensure its procedures were being properly followed. The pharmacy received a list of 'missions' to complete each morning, and again at the end of the day. These were there to ensure that essential routine tasks were carried out each day. In addition to the daily 'missions' there were also weekly ones as well. The area manager monitored the pharmacies completion of their 'missions' and this formed part of their management dashboard and contributed to the pharmacy's RAG (red, amber, green) rating. Amber or red ratings would prompt management intervention and potential escalation to ensure the necessary corrective action was taken. These were all in addition to the clinical audits carried out for the pharmacy quality scheme (PQS). There were clear audit trails to show who had carried out each of the pharmacy's activities. These included initials on dispensing labels to show who had assembled and checked them. A quad stamp was used on prescription tokens to show who had completed other steps in the process, and a barcode scanner was used to show who had handed the prescription out.

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 paper RP record was seen to be complete and up to date, although it was noted that the RP had completed the day's lunch break and closing entries in advance. When this was pointed out, he agreed to complete the record contemporaneously in future and stop making entries in advance. 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 people to see.

The pharmacy seeks people's views either directly in person or through its website with QR codes. There were prompt cards available to encourage people to give their feedback, and the till receipts also provided an email link and phone number for feedback. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display. It included contact details for the company's head office, Patient Advice and Liaison Service (PALS) and the Independent Complaint Advocacy Service. As an example, the pharmacy had received feedback from people saying they hadn't received any text messages about their prescriptions. So the pharmacy had started checking they had the correct phone number when people came to collect their prescriptions and sent them a message while they were there to check it worked. A current certificate of professional indemnity and public liability insurance was available online.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and all those inspected were complete with all the necessary details correctly recorded. Emergency supply records were also maintained electronically, complete with details of the emergency and a reason for supply. Those records of unlicensed 'specials' examined were complete and in order.

The controlled drug (CD) register was seen to be correctly maintained, with running balances 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 footnote to explain the reason for the amendment. But there was no indication of who had made those amendments. The area manager agreed to ensure that in future any amendments would be accompanied by a name and ideally a GPhC registration number so that the person making the amendment could be easily identified. There were records of CDs returned by people who no longer needed them They also showed who had subsequently destroyed them, and who had witnessed it.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. The data security and protection (DSP) toolkit had recently been completed and submitted to the NHS. Confidential waste was kept separate from general waste and shredded offsite. There was a privacy notice on display for people to see. Completed prescriptions awaiting collection were stored out of sight of people waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies, including those for children and young adults, were available in the dispensary so that staff could easily find them. The RP had been trained to level two in safeguarding, and all other staff members had been trained to level one on e-learning for health (e-LFH). Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They are well motivated, work effectively together and can make suggestions to improve safety and workflows where appropriate

Inspector's evidence

There was a full-time pharmacy technician, one full-time trainee pharmacy advisor, a locum RP and the area manager on duty during the inspection. They were working well together, supporting each other with their tasks if required. The full team comprised a mix of full-time and part-time staff who could cover any unplanned absences. They appeared to be well-supported by the area manager who explained that a new pharmacist manager would be joining the team soon. The pharmacy had been reliant upon locums for some time, but the team had kept on top of the workload.

Certificates to confirm staff qualifications were available online to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. The trainee pharmacy advisor described how she spent some time in a neighbouring branch of the company to help with her training as the regular pharmacist there acted as her tutor. The area manager showed how she could track the progress of each team member's training on her phone. The technician explained how she was about to start an accuracy checking course so that the new pharmacist would be able to spend more time on providing other services. She also confirmed that she was given an hour each week of protected learning time. Current training modules included children's cream and hay fever. Those staff questioned were able to demonstrate an awareness of potential medicines abuse and could identify people 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 was comfortable with making professional decisions and was not pressurised to compromise his 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. Team members said that they could raise concerns and that they were aware of the whistleblowing policy if they needed it.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The team keeps them clean and tidy, presenting a suitably professional image. The premises include a private room which the team uses for some of its services and for private conversations.

Inspector's evidence

There was step-free access into the pharmacy from the street through a single automated door. The premises were small but still accessible to people with pushchairs or those with mobility issues. There was a small dispensary at the rear, which was screened from public view with a small viewing hatch to those working in the dispensary could see who may be waiting at the counter. There was a workstation with the main computer on the front bench, a checking area on a bench to the rear, and a sink and further workspace around a corner towards a fire exit. All areas appeared clean and well organised.

There was a notice board and leaflet display to highlight current local health priorities and the services available from the pharmacy. 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 door was kept locked when the room was not in use. There was a small desk, with two chairs, a sink, a first aid kit and a password-protected computer inside.

The sink in the dispensary was clean, with hot and cold running water and handwash available. Team members had daily and weekly routines to keep the worksurfaces and shelving clean. Room temperatures were comfortable for staff 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 is effective at identifying people supplied with high-risk medicines who may benefit from being offered extra information to help them take their medicines safely. And it is good at keeping records of those checks and conversations. 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.

Inspector's evidence

There was a display unit with leaflets and posters highlighting health matters and some local providers. There were also signs in the window to tell people what services the pharmacy provided. The automatic door made it easier for people using wheelchairs to enter the pharmacy. There was also sufficient space for them to move around the displays or to access the consultation room.

There were controls in place to help minimise errors, such as using baskets for each prescription so that their contents were kept separate from other prescriptions. Dispensing labels included ‘dispensed by’ and ‘checked by’ boxes to indicate who had carried out those tasks. The pharmacy also annotated the prescription tokens to show who had carried out the clinical check on each prescription. Each medicine’s barcode was scanned to ensure the correct product had been selected. There was an extra process to follow if there was either no barcode or if the barcode wasn’t recognised. The area manager and technician demonstrated how their patient medication record (PMR) system highlighted any points the pharmacist needed to be aware of. It also gave them an opportunity to manually flag anything else they had identified that the pharmacist might need to know. This new process replaced the previous system of attaching paper patient information forms (PIFs). Owings slips were used when prescriptions couldn’t be supplied in full. The technician described how they contacted the prescriber to seek a suitable alternative if they couldn’t obtain the necessary medicines.

The pharmacy sent many of its prescriptions offsite for assembly at the company’s dispensing support unit in Preston. The was a procedure for identifying which prescriptions to send, and which to assemble in the pharmacy. The procedure also set out the process for clinically checking those prescriptions. The assembled prescriptions were returned to the pharmacy two days later in clearly identifiable orange tote boxes. They were then reconciled with the original prescriptions and any other items that had been assembled onsite. There was a barcode on the bag label which was scanned on handout using either a till scanner or a separate hand-held terminal. Any prompts the pharmacist may have applied, such as for providing additional counselling, had to be followed and confirmed onscreen before the bag could be handed over.

The pharmacy delivered some medicines using a team of drivers it shared with other local branches of the company. All items to be delivered were clearly labelled as such and were entered on an online portal for the drivers to access through their hand-held terminal (also referred to as PODs). The drivers ticked off each successful delivery and returned any failed deliveries back to the pharmacy. The drivers left a postcard asking people to call the pharmacy to rearrange their delivery if there was no answer at the door. Fridge lines and CDs were highlighted so that the drivers could ensure they were kept either

in the van's fridge or secure storage.

Those team members questioned were aware of the risks involved when supplying valproates to people who could become pregnant. They would check whether people had long-term contraception in place as part of the pregnancy prevention programme (PPP). These checks were included in the online prompts when handing out the prescription so that there was a record of each intervention. They also knew about the newer requirements to only supply them in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with their dispensing labels. They checked whether people taking other high-risk medicines such as lithium, warfarin or methotrexate were having the regular blood tests they needed.

The pharmacy provided the NHS Pharmacy First service, although they hadn't done very many to date. Records of each consultation were kept on the PharmOutcomes online platform. There was a file containing a referral guide, and the clinical pathways for each of the seven conditions listed in the service. The file also contained the signed PGDs for each of the prescription only medicines that could be supplied under the service. The pharmacy had also been providing the NHS hypertension case finding service and team members could describe some of their successful interventions.

The pharmacy obtained its stock from recognised pharmaceutical wholesalers. It stored its stock in the manufacturers' original containers. There was a date checking matrix on a 12-week cycle and some items of stock had been clearly marked with coloured stickers to show that they were approaching their expiry date. The area manager explained how their PMR system identified short-dated items which could be transferred to other branches who may be able to use them. The list of items for transfer was updated every Thursday. Fridge temperatures were checked and recorded every day, confirming that they were within the required temperature range. There was a flow chart for team members to follow if any of the reading fell outside of the acceptable temperature range.

The CD cabinet was securely bolted to the wall in accordance with the regulations. The pharmacy had the necessary kits to denature and safely destroy CDs. Unwanted medicines returned by people were checked for CDs and sharps. CDs were recorded before being put in the CD cupboard ready for safe destruction. Unwanted medicines were collected by an approved waste contractor.

The pharmacy received drug alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) to advise it of any recalls or other problems with medicines or medical devices. The pharmacy annotated each alert with any action taken and each team member initialled it to show that they had read it. They were then retained in a designated file.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a set of crown-stamped glass measures, with separate ones clearly marked for use only when measuring liquid CDs. There were counting triangles for counting loose tablets, with a separate one clearly marked for use only with methotrexate. They were all clean and free from visible tablet dust. The pharmacy used the BNF and BNF for children, and also had online access to other reference sources if required.

The consultation room was clean and tidy, with a small desk and two chairs. There was a blood pressure monitor for the hypertension case finding service and an otoscope which had been recently acquired for the Pharmacy First service. The technician explained that the blood pressure monitor was recalibrated every two years.

All the computers were password protected. No computer screens, or other sources of confidential information, were visible to people using the pharmacy.

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.