General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1 Bury Road, BRANDON, Suffolk, IP27 0BU

Pharmacy reference: 1037124

Type of pharmacy: Community

Date of inspection: 09/11/2022

Pharmacy context

This community pharmacy is in a semi-rural town in Suffolk, close to the Norfolk border. Its main services include dispensing prescriptions and selling over-the-counter medicines. It offers a seasonal flu vaccination service to people. And it delivers some medicines to people's homes.

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	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 identifies and manages the risks associated with most of its services effectively. It keeps people's private information secure. And it uses the feedback that it receives to inform the accessibility of its services. The pharmacy generally keeps the records it must by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns. But they do not always show how they apply learning following mistakes made during the dispensing process. This increases the chance of similar mistakes going unnoticed.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) to support its safe and effective running. The company was in the process of making all its SOPs available to team members via an electronic portal. And team members demonstrated how they accessed the portal and completed learning associated with the SOPs. A sample of individual training records identified that team members were up to date with this learning. They had recently received some updated SOPs relating to responsible pharmacist (RP) requirements. Training associated with these updates was due for completion in around a months' time. Pharmacy team members demonstrated a sound understanding of their own job roles, and of the roles of other team members. For example, the pharmacy employed some pharmacy technicians in accuracy checking technician (ACT) roles. A dispenser explained the process followed by the pharmacy team that ensured a pharmacist clinically checked a prescription prior to an ACT completing the accuracy check of a medicine.

The team acted with care by acknowledging safety prompts provided by the computer system when dispensing medicines. A team member demonstrated how using barcode technology reduced the risk of mistakes as the system alerted team members if the wrong product or unexpected pack size was scanned. The system did not recognise every barcode, and when this event occurred the team flagged the prescription for a second check before it was passed to the accuracy checker. Pharmacy team members were encouraged to reflect on mistakes made and identified during the dispensing process, known as near misses. But they did not always take the opportunity to record these mistakes. A team member led the patient safety review process. But reviews in recent months lacked comments related to the trends in mistakes. And comments within the reports identified the need to increase reporting rates. Additional comments stated that team members would share learning through team discussions. But team members explained this had not happened for some time due to increased workforce pressures. This meant it was more difficult for the team to demonstrate how it shared learning from these types of mistakes. The pharmacy team did record mistakes where a medicine reached a person, known as dispensing errors. And the RP discussed how these mistakes were recorded. The reporting process prompted follow up action to reduce the risk of a similar event occurring.

The pharmacy manager completed some ongoing monitoring checks to ensure the team remained up to date with key tasks including record keeping. The pharmacy had up-to-date indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy generally kept the records required by law in good order. There were some minor improvements identified in the controlled drug (CD) register as the pharmacy team did not always record the address of the wholesaler when entering the receipt of a CD in the register.

The pharmacy maintained running balances in the register. And the team completed regular full balance checks of physical stock against the register. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. A patient-returned CD destruction register was maintained. But some records in the register identified that these returns were not always destroyed in a timely manner as CDs returned in August 2022 were still waiting for destruction. The pharmacy team retained certificates of conformity relating to the supply of unlicensed medicines. But it did not always complete the necessary audit trails on these certificates to identify the prescriber, and details of the person the medicine had been supplied to. This meant it could be more difficult for the pharmacy to answer queries about the supply of these medicines.

The pharmacy had a complaints procedure and this was advertised clearly. Pharmacy team members recognised how they would manage feedback and understood how to escalate a concern when required. They discussed an increase in concerns about accessibility due to the pharmacy needing to close on occasion due to a lack of pharmacist availability. The pharmacy was advertising for a regular pharmacist to help reduce these kind of events. The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated bags. And these bags were sealed and sent for secure disposal regularly.

The pharmacy had procedures in place to support team members in recognising and reporting safeguarding concerns. And team members completed mandatory safeguarding learning. Both pharmacists on duty had confirmed completion of level two safeguarding learning before commencing work for the company. Pharmacy team members provided several examples of safeguarding concerns that they had shared with people's own GPs. The pharmacy prominently advertised that it offered a safe space for people to use. And its team members were aware of how to respond to safeguard a person through the 'Ask for ANI' safety initiative, designed to protect people suffering domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy services are provided by a dedicated team of people who work together well. The pharmacy provides its team members with some support to complete ongoing learning associated with their roles. And its team members understand how to provide feedback and raise concerns at work. But due to increasing working pressures they don't have regular opportunities to engage in shared learning designed to improve patient safety.

Inspector's evidence

The RP was supported by a second pharmacist, four qualified dispensers and a trainee dispenser. The pharmacy also employed another trainee dispenser, a full-time ACT, a part-time ACT and the pharmacy manager, who was a qualified dispenser. Some team members working part-time hours worked overtime to cover leave within the team. Company employed delivery drivers provided the medicine delivery service. The pharmacy did not have a regular pharmacist. Both pharmacists on duty were locums, they demonstrated sound knowledge of the pharmacy's procedures. Team members explained that there was sometimes difficultly in obtaining a pharmacist, and on some occasions, it had only opened for half a day. This was through an arrangement where it rotated half-day opening with another Boots pharmacy, within walking distance. This allowed a pharmacist to be present at each pharmacy for part of the day. The pharmacy team confirmed that closures were reported to the NHS as required. They explained that the closures meant work backed up and this increased workload pressure. Some assembled medicines waiting to be checked were due for collection. The team worked quickly to identify and prioritise these medicines when people attended to collect them. They also promoted a text messaging service to inform people when their medicine was ready to collect, and this did reduce the number of people attending the pharmacy ahead of their medicine being due for collection.

Pharmacists explained that specific targets had not been discussed with them ahead of booking their shifts. They explained that supporting the provision of services such as the NHS New Medicines Service (NMS) formed part of their role. And team members provided pharmacists with information about tasks required for the day at the beginning of their shift. Pharmacy team members received some time in work to complete learning, but this time was not protected. They engaged in a structured appraisal process to support their learning and development. A trainee dispenser described feeling supported through their learning. But there had been some delay in enrolling the trainee on the accredited learning course. This delay had been caused by several factors, most of which were not in the direct control of the pharmacy.

Discussions in the pharmacy focussed very much on task management. And the team expressed that there was little opportunity to support more detailed discussions designed to share learning due to how busy the pharmacy was. Pharmacy team members were good at working together to support the delivery of pharmacy services. For example, they had a daily rota to ensure a team member was covering the medicine counter at all times. The pharmacy had a whistle blowing policy to support team members in raising and escalating concerns at work. And its team members knew how to raise a concern and put forward ideas for improvement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe, secure, and appropriately maintained. They provide a suitable space for providing healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. Pharmacy team members understood how to report maintenance concerns. And they provided details of two recent maintenance concerns they had reported, both of which were in the process of being dealt with. The pharmacy was generally clean, but there was some dust build-up behind computer workstations in the dispensary. Lighting was bright throughout the premises and air conditioning supported the pharmacy in maintaining an ambient room temperature. Pharmacy team members had access to sinks equipped with antibacterial hand wash, sanitiser gel and paper towels.

The public area was fitted with wide-spaced aisles and provided access to a range of healthcare and personal care products. A consultation room was clearly advertised to the side of this area. The door to the room was kept locked between use. The room was clean and professional in appearance. It offered a suitable space for holding private consultations. The medicine counter was positioned in front of the dispensary, and access beyond the counter and into the dispensary was monitored through staff vigilance. The dispensary was an appropriate size for the level of activity taking place. There was adequate workstations set up to support the high volume of prescriptions the pharmacy dispensed. Off the back of the dispensary was a wide corridor fitted with shelving, this was used as a storeroom for overflow retail stock, dispensary sundries and some paperwork. Off the corridor there was access to staff toilet and kitchen facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. On occasions when it is unable to provide a service or supply a medicine the pharmacy team appropriately signposts people to other healthcare providers. The pharmacy obtains its medicines from licensed sources. And it generally stores its medicines safely and securely. Pharmacy team members work safely and effectively to manage the pharmacy's services. They provide people with relevant information about the medicines they are taking. And they engage people in conversations about their health and wellbeing.

Inspector's evidence

People accessed the pharmacy through a power-assisted door at street level. The pharmacy clearly advertised its opening times and details of its services for people to see. It provided seating for people wishing to wait for their medicine or for a service. Pharmacy team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine. And they provided examples of how they had worked together with a local Boots pharmacy to ensure people had access to pharmacy services when one of the pharmacies had needed to close in recent months.

Pharmacists had access to up-to-date patient group directions (PGDs) to support the safe delivery of the flu vaccination service. The pharmacy had an online booking system for this service and the RP explained how this helped the team to plan workload. For example, it generally closed bookings if only one pharmacist was available due to the high volume of dispensing activity. Pharmacy team members worked well together to support the delivery of other services such as the NMS. They made records available for pharmacists on the day follow-up consultations were due to ensure these consultations took place. The pharmacy was very busy, but team members were observed taking the time to speak to people about their health and wellbeing, and referred people to speak to a pharmacist when required.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. And pharmacists could supervise activity in the public area adequately. A pharmacy team member demonstrated how the patient medication record (PMR) system identified higher-risk medicines, or medicines prescribed for a child. And discussed important safety steps during the dispensing process, such as the appropriate placement of dispensing labels on packaging. The PMR also generated a 'pharmacist information form' (PIF). PIFs contained key information about the prescription such as dose changes and new medicines. And pharmacy team members could add more information to the PIF to bring information to the attention of pharmacists and ACTs. Pharmacy team members identified and managed higher-risk medicines during the dispensing process by using bright alert cards which they kept with prescription forms up until the medicine was handed out to people. The alert cards prompted a series of checks during the dispensing process, and provided guidance to support pharmacists in supplying higher-risk medicines. For example, a purple alert card was designed to support pharmacists and the team in meeting the requirements of the valproate Pregnancy Prevention Programme (PPP). The RP explained that whilst patient cards were supplied with valproate to people in the at-risk group, the card was not personally handed over as part of the counselling process. And the RP explored ways in which the team could improve this by making its approach when providing counselling. For example, by keeping the card with the prescription form, alert card and PIF to help

support the handout process. The team provided examples of counselling associated with the supply of other higher-risk medicines such as lithium, warfarin, and methotrexate. But it did not always receive monitoring information to help inform the supply of these medicines. Pharmacists confirmed that they made counselling notes on the PMR to help support ongoing care. The pharmacy team also used alert cards and stickers to prompt additional checks of medicines requiring cold storage, and CDs. This included checking the pharmacy supplied a prescription calling for a CD within 28 days of the date of prescribing.

The pharmacy had audit trails to support it in ordering prescriptions on people's behalf. This helped it chase missing prescriptions and manage queries. The pharmacy kept each person's prescription separate throughout the dispensing process by using tubs and baskets. And there was a clear system to manage owed medicines. The pharmacy maintained an electronic audit trail of the medicines it delivered. And team members contacted people by telephone to arrange the delivery. This supported the team in providing information about people's medicines. And it allowed people to ask any questions they had about their medicines or general health. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed an audit trail on prescription forms to identify the person completing the labelling stage, the picking and assembly stage, the clinical check of the prescription, the final accuracy check, and the handout process. Labels attached to bags of assembled medicines contained unique barcodes. Team members scanned this barcode along with a barcode from the storage location where the bag and attached prescription was placed. They demonstrated how this efficiently supported them in retrieving assembled medicines when people came to collect them. And explained how the process supported them in reducing handout errors as the process no longer required them to match a prescription form from a separate retrieval system with the correct bag of assembled medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in their original packaging in an orderly manner. The pharmacy stored CDs in secure cabinets and storage of medicines within each cabinet was organised. It had specific areas within a cabinet for holding assembled medicines awaiting checking, checked medicines awaiting supply, out-of-date medicines, and patient-returned medicines. The pharmacy had two medical fridges and it held medicines inside each fridge an orderly manner. The pharmacy monitored its fridge temperatures and recorded these daily (Monday-Saturday). The records showed both fridges were generally operating within the accepted temperature range of two and eight degrees Celsius. One fridge was accessed more frequently than the other, and the maximum temperature recorded had been slightly higher than eight degrees over the last few days. The team thought this could be due to temperature increases when the door was open. Team members were actively monitoring this situation and they understood how to escalate any concerns with the fridge should the situation continue.

The pharmacy team appeared to be behind with date checking tasks, a matrix used to support this process had not been completed since August 2022. But team members indicated that some checks may have been completed but not recorded since this date. A random check of dispensary stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. Some team members routinely checked expiry dates when picking and assembling medicines. But other team members acknowledged they may not always do this. This meant there was an increased reliance on the accuracy checking process to identify an out-of-date medicine. The pharmacy had medicine waste bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. It received medicine alerts electronically, and team members were required to respond to these alerts. A team member demonstrated that all alerts had been checked to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

The pharmacy team had access to up-to-date written and electronic reference resources. Team members could also access information resources via the intranet, internet, and a designated telephone support line. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines in an area to the side of the dispensary. Details on bag labels and prescription forms could not be read from the public area. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. And they moved out of earshot of the public area when the phone call required privacy.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. This included crown-stamped measuring cylinders for measuring liquid medicines and equipment for counting capsules and tablets. There was separate equipment available for counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Pharmacists running the flu vaccination service had access to appropriate equipment to support them in providing this service. The equipment included immediate access to medicines and equipment used to treat an anaphylactic reaction. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society. The pharmacy maintained its equipment to help ensure it remained safe to use and fit for purpose. For example, electrical equipment was subject to regular portable appliance testing.

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.