General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Units 2-4 Market Place, The Martlets, BURGESS HILL, West Sussex, RH15 9NP

Pharmacy reference: 1037276

Type of pharmacy: Community

Date of inspection: 23/11/2022

Pharmacy context

This is an NHS community pharmacy set in a shopping centre in Burgess Hill. The pharmacy is part of a large chain of pharmacies. It opens seven days a week. It sells over-the-counter medicines. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get their flu vaccination (jab) at the pharmacy too.

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	The pharmacy identifies and manages its risks very well.
		1.2	Good practice	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
2. Staff	Good practice	2.2	Good practice	The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills.
		2.4	Good practice	Members of the pharmacy team work well together and have a clear work culture of openness, honesty and learning.
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 its risks very well. It has written instructions to help its team members work safely. It continually monitors the safety of its services to protect people and further improve patient safety. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make and learn from them to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had a business continuity plan. This identified the potential risks to the pharmacy, its services and its team in the event of an emergency. The pharmacy had considered the risks of coronavirus. And, as a result, it put some plastic screens on its counters to try and stop the spread of the virus. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by a team at the pharmacy's head office. Team members were required to read, complete training on and sign the SOPs relevant to their roles to say they understood them and would follow them. The pharmacy carefully managed its dispensing workflow to reduce the chances of its team making mistakes. It generally kept its pharmaceutical stock alphabetically. And its team separated a few medicines which were similar in some way, such as those that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. Members of the pharmacy team responsible for making up people's prescriptions kept the dispensing workstations tidy. They used plastic containers to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They scanned the bar code of the medication they selected to check they had chosen the right product. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the responsible pharmacist (RP). The pharmacy had robust processes to deal with patient safety incidents and dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). And the safety and the quality of its services were reviewed and monitored during regular compliance audits. Members of the pharmacy team recorded the mistakes they made and any lessons they learnt from them. They reviewed their mistakes regularly to help them spot patterns or trends. And they shared any learnings with one another during regular team meetings. So, they could try to stop the same sorts of mistakes happening again and improve the safety of the dispensing service they provided. And, for example, they recently reviewed and strengthened their dispensing process to make sure people got the right number of tablets.

The pharmacy displayed a notice that told people who the RP was at that time. Members of the pharmacy team wore name badges. They 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 couldn'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. People shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets which asked people to share their views and suggestions about how the pharmacy could do things better. And, following feedback, the pharmacy team now used a secure email system to enquire about non-urgent prescription issues. This meant it spent less time on the telephone with local surgeries dealing with these types of matters. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were checked as often as the SOPs asked them to be. But the details of where a CD came from weren't always completed in full. The pharmacy kept appropriate records to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But some details were occasionally incomplete in the private prescription records and the reason for making an emergency supply wasn't always recorded properly. The pharmacy kept a record for the supplies of the unlicensed medicinal products it made. But its team sometimes forgot to record when an unlicensed medicinal product was received, when it was given out and who it was supplied to.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had policies on information governance and safeguarding. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of. Members of the pharmacy team were required to complete training on information governance and safeguarding. They knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. They were aware of the 'Ask for Ani' campaign. And they could help people get the support they needed if they were asked.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it encourages them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP), a full-time trainee pharmacist, two full-time pharmacy advisors, two part-time pharmacy advisors, a part-time medicines counter assistant (MCA) and a trainee MCA. The store manager and the assistant manager were also trained pharmacy advisors. So, they could help the pharmacy team when needed. The RP, the trainee pharmacist, three pharmacy advisors and the MCA were working at the time of the inspection. The pharmacy relied upon its team, locum pharmacists and team members from another branch to cover absences. Members of the pharmacy team were up to date with their workload. They worked well together and helped each other to serve people and dispense prescriptions safely. The RP led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

The pharmacy had an induction training programme for its team. And this included the trainee pharmacist. The trainee pharmacist confirmed that the RP was their designated supervisor. And there was a training plan in place for their foundation training year. The trainee pharmacist felt supported. They were encouraged to improve their skills and attend regular training events with other trainee pharmacists. They had regular discussions and reviews with the RP. And they received time to study. Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with their line manager. And they helped each other to learn. Team members were encouraged to ask questions and familiarise themselves with new products. They kept their knowledge up to date by completing online training. They had time set aside while they were at work to train and support their development. But they could choose to train in their own time too. Members of the pharmacy team were comfortable talking about their own mistakes with their colleagues. And team meetings and one-to-one discussions were held so they could update each other and share learning from mistakes or concerns. The pharmacy team didn’t feel the targets set for the pharmacy stopped it from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to them marking people’s prescriptions to highlight when additional items needed to be added.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was set in a medium-sized Boots store. And its registered area consisted of a consulting room, two counters, a dispensary and several bays of back wall shelving. The premises were air-conditioned, bright, clean and professionally presented. But some areas were showing signs of wear. The pharmacy had the workbench and storage space it needed for its current workload. It used its consulting room for the services it offered that required one and if people needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The store was regularly cleaned by a cleaning contractor. And the pharmacy team was responsible for keeping the pharmacy area clean and tidy. The pharmacy had a sink and a supply of hot and cold water. And its team regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it offers flu jabs and keeps appropriate records to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The store was located on the ground floor of a shopping centre. It had an automatic door. Its entrance was level with the shopping centre's flooring. And the area leading to the pharmacy was kept clear. This made it easier for people to enter the building and access the pharmacy and it services. But the pharmacy had recently reduced its opening hours. The pharmacy had some notices that told people about its products and the services it delivered. And it had a small seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. Members of the pharmacy team were friendly and helpful. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a paid-for delivery service to people who couldn't attend its premises in person. It kept an electronic audit trail for each delivery. And this showed it had delivered the right medicine to the right person. The people who provided the delivery service were based at a different branch. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu jab service. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The RP asked another appropriately trained team member to check they had chosen the correct vaccine before administering it. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the RP assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And its team usually provided a brief description and a patient information leaflet for each medicine contained within the compliance pack. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder cards and notes to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. But a few medicines weren't. This made it difficult for the pharmacy team to tell if it had all the information needed if a particular make of medicine was recalled. Members of the pharmacy team checked the expiry dates of medicines at regular intervals. They recorded when they did these. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the Chief Pharmacist's Office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. The pharmacy had a monitor its team could use to measure a person's blood pressure. And this was replaced every two years. 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 their NHS smartcards were stored securely when they weren't 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.