General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 87-87A High Street, Harborne, BIRMINGHAM, West Midlands, B17 9NR

Pharmacy reference: 1038026

Type of pharmacy: Community

Date of inspection: 26/09/2019

Pharmacy context

This community pharmacy is on a high street and generally receives NHS prescriptions from four local GP surgeries. There is a large population of students and staff from the local university who use the pharmacy. The pharmacy supplies medicines to many care homes. It provides a sexual health service which includes the supply of emergency hormonal contraception.

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	1.8	Good practice	The pharmacy's team members take the right actions to protect vulnerable people.
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 generally manages its risks well. It reviews its dispensing process to make improvements to safety. It generally keeps the records that it needs to, and these are mostly accurate. The pharmacy's team members manage people's personal information well. They take the right actions to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered its services. The SOPs were kept up to date and were signed by the pharmacy's team members to show that they had read them. The responsible pharmacist's name and registration number was displayed on a notice in the retail area.

The pharmacy kept records about near misses in the dispensing service. It regularly reviewed the records to identify trends and discuss learning. A recent review stated that opened medicines packaging had been clearly marked to reduce the chance of supplying the incorrect quantity of medicines. The pharmacy highlighted 'lookalike and soundalike (LASA)' medicines to reduce the chances of them being mixed-up.

One of the team members was the 'Patient Safety Champion' for the pharmacy. This involved reviewing the pharmacy's near miss log and sharing learning points from the pharmacy's monthly newsletter. Team members signed a record to show that they had read the newsletter. The team had recently discussed the flu vaccination service and the eligibility for this service. The team discussed case studies and identified learning points.

The pharmacy regularly asked people visiting the pharmacy to complete satisfaction surveys. The previous survey's results were generally positive. There was some negative feedback about the comfort and convenience of the waiting areas. Team members had rearranged some areas of the retail area to create more space. The pharmacy had trialled an 'express prescription pickup queue' but had not implemented it permanently because of some negative feedback. The pharmacy was due to be refurbished to create more space. Concerns and complaints were referred to either the responsible pharmacist or the care homes business manager.

The pharmacy had contact details for local safeguarding organisations which made it easier to escalate concerns. It kept records about safeguarding training that some team members had received from the Centre for Pharmacy Postgraduate Education (CPPE). Team members also received training through the pharmacy's E-learning platform. The pharmacy had escalated a concern about a vulnerable adult to their head office and the GP surgery.

The pharmacy had procedures about information governance and confidentiality. Confidential waste was separated from other waste so that it could be appropriately destroyed. Most team members had their own NHS smartcards to access electronic prescriptions. Other team members were in the process of getting their own smartcards to use. A statement that the pharmacy complied with the Data Protection Act and NHS code of conduct on confidentiality was in its practice leaflet.

The pharmacy had current arrangements for liability and indemnity insurance. The pharmacy kept required records about its controlled drugs (CDs). It recorded running balances and checked these regularly to make sure that the records were accurate. Three CDs were chosen at random and the physical stock matched the recorded running balances. The pharmacy kept appropriate records about CDs that had been returned by people. Its responsible pharmacist records were generally adequate but there were some entries which didn't include the sign-out time of the pharmacist on duty. These entries were highlighted to a team member, so they could be corrected. The pharmacy's private prescription records were generally accurate, however there were some entries where the prescriber details or prescription dates were incorrect. These entries were highlighted to a team member, so they could be corrected. The pharmacy kept appropriate records about unlicensed medicines it supplied.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy manages its workload adequately. It makes sure that team members who work in the pharmacy can provide its advertised services. The pharmacy's team members have appropriate pharmacy qualifications and they complete regular training to keep their knowledge up to date.

Inspector's evidence

The pharmacy's staffing level was adequate to manage its workload. Many team members had worked at the pharmacy for several years and this allowed them to complete tasks more efficiently. The pharmacy used an offsite dispensary to help manage some of its workload. There were two vacancies for two full-time pharmacists. The pharmacy was in discussions to have one of these vacancies filled. Relief pharmacists were usually used to cover the working hours because they had received training to provide the pharmacy's services. Team members were competent in their roles and they asked for more support when they needed. A pharmacy technician showed a dispenser how to process a veterinary prescription. Another dispenser asked the pharmacist about a suspected eye infection. After being given information from a pharmacist, a dispenser telephoned a GP surgery to query an unusual medicine dosage which had been prescribed for a child. The pharmacy's team members used informal discussions to share information. The pharmacist provided feedback to team members during informal discussions.

The pharmacy kept records the dispensers' pharmacy qualifications. It used its E-learning platform to provide regular training. Some topics included health and safety or safeguarding. The pharmacy provided clinical modules to its team members. A recent module focussed on e-cigarettes. Team members said that they did not have time set aside to complete the training. They said that they would find time to complete the training during quieter periods.

The pharmacy had targets about its services. Team members said that they did not feel undue pressure to achieve the targets. They said that they felt adequately supported by senior managers, who had a plan for recruiting new team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides its services from suitable premises. It has enough space to dispense and store medicines. And it has appropriate security arrangements to protect its premises.

Inspector's evidence

The pharmacy was generally clean and tidy. The pharmacy's head office was planning to refurbish the premises to improve the available storage and space. Medicines supplied to care homes were dispensed in a separate area so there was enough space and fewer distractions. Its team members kept workbenches tidy so that there was enough space to complete tasks safely. There was adequate heating and lighting throughout the pharmacy. The pharmacy had hot and cold running water available. The pharmacy had a suitably-sized consultation room which was suitable for private consultations and conversations. And it had appropriate security arrangements to protect its premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy organises its services and generally manages them well. It stores its medicines appropriately, so they are safe for people to use. Its team members take the right action when they receive information about medicine recalls. They identify higher-risk medicines, so they can provide appropriate advice to people.

Inspector's evidence

The pharmacy's layout and step-free access made it easier for people in wheelchairs to use the pharmacy. The pharmacy had leaflets that provided information about its services. People mostly ordered their own prescriptions. The pharmacy ordered prescriptions for some people. It kept records about prescription orders it had made so that its team members could check the prescriptions included all the required medicines. The pharmacy had invoices which showed that its medicines were obtained from licenced wholesalers. It used fridges to store medicines that needed cold storage. The pharmacy's team members recorded daily fridge temperatures to make sure the fridge stayed at the right temperatures. CDs were stored appropriately. CDs which had gone past their 'use-by' date were separated from other stock to prevent them being mixed up.

The pharmacy checked its stock's expiry dates regularly. It kept records about checks that it completed and medicines that had gone past their 'use-by' date. The pharmacy was up to date with its date-checking schedule. Medicines that were approaching their expiry date were highlighted to the team. Several medicines were checked at random and were in date. The pharmacy wrote the date onto medication bottles when they were first opened. This helped the team members to know that the medicine was suitable if they needed to use it again. Date-expired and medicines people had returned were placed in to pharmaceutical waste bins. These bins were kept safely away from other medicines. A separate bin was used to segregate cytotoxic and other hazardous medicines. Team members did not have a list to refer to, so they may have found it more difficult to identify hazardous or cytotoxic medicines.

The pharmacy did not currently have equipment or software to help verify the authenticity of its medicines and to comply with the Falsified Medicines Directive. Its head office was in the process of making arrangements for the required processes. The pharmacy received information about medicine recalls from its head office. It kept records about the recalls it had received and the actions that had been taken. A recent recall had been actioned for bisacodyl suppositories.

Dispensers used baskets and tubs to make sure prescriptions were prioritised and medicines remained organised. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to provide an audit trail. The pharmacy's dispensing software highlighted interactions to the team and these were communicated to the pharmacist using written notes ('pharmacist information forms'). Prescriptions were kept with checked medicines awaiting collection. The pharmacy used stickers to highlight medicines that needed to be supplied within 28 days of the prescription date.

Stickers and laminated notes were used to highlight dispensed medicines that needed more counselling or advice. This included methotrexate, lithium and warfarin. The pharmacy kept records about relevant blood tests for people who were supplied with warfarin. The pharmacy team was aware about

pregnancy prevention advice to be provided to people in the at-risk group taking sodium valproate. The pharmacy had up-to-date guidance materials to support this advice. The pharmacy delivered some people's medicines. It kept appropriate records about the deliveries to people and care homes. Records included recipient signatures which helped to identify who had received a delivery.

The pharmacy supplied medication to many care homes. It arranged the workload across four weeks to help it be more organised. Most care homes received medicines in the manufacturer's original packaging. Prescriptions were ordered in good time so that the pharmacy could identify missing prescription items or chase-up queries. The pharmacy kept appropriate records about the medicines that had been ordered. Prescriptions were clinically checked by a pharmacist. Team members recorded information about relevant blood tests or other clinical information that was needed for higher-risk medicines. The initials of clinical checkers, dispensers and accuracy checkers were recorded to provide an audit trail. The pharmacy kept records about the communications with care homes and these were reviewed when there were queries about medicines that should have been supplied. The care homes dispensary had a separate telephone line so that queries about the care homes could be efficiently managed. Care homes were regularly visited by a pharmacist to discuss any queries. Patient information leaflets were provided to the homes so that staff had up-to-date information about the medicines that had been supplied.

The second pharmacist described the training that she had received to provide the sexual health service. This included face-to-face and online training which was repeated every year. The training included training about safeguarding vulnerable adults and children. The pharmacy had a patient group direction (PGD) which specified how the service should be provided. It used electronic software to record consultations and this helped to make sure that any supplies of medicines were according to the PGD.

The pharmacy provided NHS and private flu vaccinations. It had a PGD which specified the requirements of the service. Team members received training, so they knew about the service and who it could be offered to. The pharmacists received training about consultation skills and first aid to provide the service. A declaration of competence had been signed to show that the pharmacy could provide the service. The pharmacy kept appropriate records about the vaccinations it administered to people and shared this information with people's GP surgeries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities to provide its services. Its team members know how to report maintenance issues. And they use up-to-date reference sources when they provide the pharmacy's services.

Inspector's evidence

The pharmacy's equipment appeared to be in good working order and maintained adequately. The pharmacy had a contact number to report maintenance issues. Confidential information was not visible to people visiting the pharmacy. Computers were password protected to prevent unauthorised access to people's medication records. The pharmacy had appropriate measures to accurately measure liquids. Separate measures were used for CDs. The pharmacy's team members accessed up-to-date reference sources on the internet.

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.