

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 8B Altrincham Retail Park, George Richards Way, Broadheath, ALTRINCHAM, Lancashire, WA14 5GR

Pharmacy reference: 1090041

Type of pharmacy: Community

Date of inspection: 23/08/2019

Pharmacy context

This is a pharmacy situated in a large retail park store in a suburban residential area, serving the local population. It mainly supplies NHS prescription medicines and orders prescriptions on behalf of people. It also provides other services such as influenza, meningitis B and chicken pox vaccinations.

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	2.1	Good practice	Staff do not feel pressurised when working and complete tasks properly and effectively in advance of deadlines. And the pharmacy reviews its staffing levels so that they remain appropriate.
		2.2	Good practice	New members of the pharmacy team complete training on time. Staff also complete regular ongoing training relevant to their roles to help keep their skills and knowledge up to date. And they have protected time to learn when they are at work.
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 on the whole manages the risks associated with its services well. The pharmacy team follows written instructions to help make sure it provides safe services. The team records and reviews any mistakes so that it can learn from them. Team members receive training on protecting people's information, and they understand their role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy had written procedures that it regularly reviewed. These covered the safe dispensing of medicines, responsible pharmacist (RP) regulations and controlled drugs (CDs). Records indicated that staff had read and understood each procedure. And the resident pharmacists counter-signed these records when they observed each staff member consistently adhering to the procedures. Staff also had their knowledge of procedures regularly tested. So, each team member had a clear understanding of the procedures that were relevant to their role and responsibilities.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each supply of prescription medication. And it assisted with investigating and managing mistakes. The team regularly discussed the patient-safety case studies that the pharmacy's superintendent office had issued. Pharmacy team members recorded and discussed any mistakes they identified when dispensing medicines and addressed them separately. The resident pharmacists reviewed these records each month and shared the key learning points with the rest of the team. However, staff usually did not record the reason why they thought they had made each mistake. So, they could miss additional opportunities to learn and mitigate against risks in the dispensing process.

The pharmacy team received positive feedback from people who used its services across several key areas in its last satisfaction survey conducted between April 2018 and March 2019. Publicly displayed leaflets explained how people could make a complaint and the team had read the pharmacy's complaint procedures, so it could effectively respond to them.

The pharmacy had professional indemnity insurance for the services it provided. The RP, who was an employee relief pharmacist providing temporary cover, prominently displayed their RP notice, so people could identify them. The pharmacy maintained the records required by law for the RP, medicines urgently supplied to people at their request, private prescriptions and CD transactions. And it checked its CD running balances regularly, which helped to detect any discrepancies at an early stage. It also maintained its records for CD destructions, influenza, meningitis B and chickenpox vaccinations, Medicines Use Reviews (MURs), emergency hormonal contraception (EHC), minor ailment consultations and specials medications that the pharmacy had supplied.

All team members had completed the pharmacy's annual data protection training. And they used passwords to protect access to electronic patient data and disposed of confidential material securely. However, the team had positioned a computer screen on the top of its open-plan front counter at an angle that meant people's electronic information could be seen from the public area, but it subsequently addressed this oversight. The team did not always complete the pharmacy's weekly data

protection audits.

All three resident pharmacists had level two safeguarding accreditation, and all staff had completed the pharmacy's annual safeguarding training. They recalled discussing their concerns with the GP when people exhibited signs of confusion. And staff helpfully reminded these people when they struggled to recall what they had previously consulted the pharmacy about.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to provide safe services and reviews its staffing levels so that it can respond to changes in workload. And the team members have the skills and experience needed for their roles. Each team member has a performance review and completes relevant training on time, so their skills and knowledge are up to date.

Inspector's evidence

The staff present included the RP and an experienced full-time dispenser. The other staff included three resident pharmacists, an experienced dispenser, an assistant store manager who was an accredited medicines counter assistant (MCA) and dispenser, a second assistant store manager who was training to be an MCA and dispenser, a trainee who was completing their MCA and dispenser training, and one store-based staff member who was training to be an MCA and dispenser.

The pharmacy usually had enough staff to comfortably manage the workload. The team had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via the electronic prescription service and around a third of them through its prescription ordering service. It had a steady flow of people presenting for its services. And the store management team and staff in training provided additional cover that the pharmacy could call on when members of the pharmacy team took a break and planned or unplanned leave. Only one staff member was allowed planned leave at any time, and relief dispensers were available to provide temporary cover if needed. This helped the team to avoid sustained periods of increased workload pressure and it could promptly serve people.

Staff worked well both independently and collectively. They used their initiative to get on with their assigned roles and did not need constant management or supervision. The dispenser had a sound knowledge of how the pharmacy provided its services, and the store management as well as the dispensers provided the compliance pack service.

The team was up-to-date with the pharmacy's mandatory e-learning training that covered its policies, procedures and services. And staff had protected study time to complete their training. Each team member also had a recent performance appraisal. The staff in training were progressing well towards qualification. They received helpful support from the resident pharmacist and had protected study-time. The manager and store-based trainee also worked regularly each week in the dispensary, which helped to make sure their skills were maintained.

The pharmacy had targets for the number of MURs it completed, and the combined revenue of its vaccination services. Staff said that the MUR and vaccination targets were realistic and they could manage the competing MUR vaccination and dispensing workloads. For example, it would re-arrange an MUR consultation when the pharmacist was providing the vaccination service and advised patients of longer prescription medication waiting times when the pharmacist was conducting a consultation. The pharmacy obtained people's written consent for MURs, NMS, influenza meningitis B and chickenpox vaccination, which meant it could effectively show they requested these services.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are clean, safe, secure and spacious enough for the pharmacy's services. It has a private consultation room where members of the public can have confidential conversations.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. The premises had the space that the team needed to dispense medicines safely. And staff could secure it to prevent unauthorised access. One of the consultation rooms provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility. The other consultation room was a cubicle with low-level walls and no ceiling, which risked confidential discussions being heard outside the room.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's working practices are suitably effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers and manages them appropriately to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was open extended hours Monday to Friday and across the weekend. The store had a step-free entrance, automatic front doors and wide aisles leading to the pharmacy. All three resident pharmacists had influenza vaccination accreditation and two of the three had meningitis B and chickenpox vaccination accreditation, which meant people could access these services across most of the week. People accessed the meningitis and chicken pox vaccination services via an appointment system. However, staff said that both these vaccination services were not available at the weekend, when they received a significant number of requests for them.

The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including insulin, anti-coagulants, methotrexate and lithium. The team regularly checked if people on anti-coagulants and methotrexate had a recent blood test, if they were experiencing side effects or interactions with each prescription it dispensed and counselled them if necessary. Staff had discussed case studies on valproate that the superintendent's office had issued, so knew about dispensing it safely. The team had checked people being supplied valproate and did not have anyone in the at-risk group. It had the MHRA approved valproate advice cards and booklets to give people if needed.

The team prompted people to confirm the repeat medications they required, which helped limit medication wastage and made sure people received their medication on time. However, it did not make any records of the medications requested, so could find it difficult to effectively resolve queries about requests. The staff said that the pharmacy would shortly have an electronic system to address this.

The team scheduled when to order compliance pack people's prescriptions and kept records of the progress made towards dispensing their medication, which helped to make sure it supplied their medication in good time. The team kept a record of these people's current medication that also stated the time of day they should take them. This helped it effectively identify and query any medication changes with the GP surgery. The pharmacy kept detailed records for verbal communications it had about medication queries or changes for people on compliance packs. The team labelled compliance packs with a description of each medicine inside them, which helped people to identify them.

The team consistently used a formal checklist to review and communicate clinical matters about people's prescriptions. It used tubs during the dispensing process to separate people's medications, which also helped to organise its workload. It marked part-used medication stock cartons, which helped make sure it gave people the right amount of medication.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored all of them in an organised manner. Staff said that they had been briefed on the significance of

the Falsified Medicines Directive (FMD) and the pharmacy should have the system needed to comply with it by November 2019, so was not yet following the FMD, as required by law.

The team suitably secured its CDs, quarantined its date-expired and patient-returned CDs, and had destruction kits for destroying CDs. It monitored its refrigerated medication storage temperatures, and records indicated that the team had monitored medicine stock expiry dates over the long-term. The team took appropriate action when it received alerts for medicines suspected of not being fit for purpose and recorded the action that it had taken. It disposed of obsolete medicines in waste bins kept away from medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable.

The team used an alpha-numeric system to store people's dispensed medication, which meant it could efficiently retrieve patient's medicines when needed. The pharmacy made sure it only supplied CDs when it had a valid prescription. The staff wrote the supply deadline date on stickers that they applied to dispensed CDs which reminded the pharmacist to check the date before supplying them. And the resident pharmacists regularly reviewed the stored dispensed CDs each week. Records showed that the pharmacy securely delivered medication to people.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. It properly maintains its equipment and it has the facilities to secure people's written and electronic information.

Inspector's evidence

The pharmacy team kept the dispensary sink clean, which had hot and cold running water and an antibacterial hand-sanitiser. The team also had a range of clean measures. So, it had the facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. Staff had access to the latest versions of the BNF and cBNF to check pharmaceutical information if needed.

The pharmacy's PMR system had the capability to retrieve people's electronic information stored on it in the event of its failure. The pharmacy had facilities to store people's medicines and their prescriptions far enough away from public view.

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.