

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, Unit B4, Bentley Bridge Retail Park, Bentley, WEDNESFIELD, Wolverhampton, WV11 1BP

**Pharmacy reference:** 1090084

**Type of pharmacy:** Community

**Date of inspection:** 18/10/2022

## Pharmacy context

This community pharmacy is located within a large Boots store on Bentley Bridge Retail Park, close to Wolverhampton city centre. The pharmacy is open extended hours over seven days. It dispenses NHS prescriptions, provides NHS funded services and some private services are also available. The pharmacy team dispenses medicines into multi-compartment compliance packs for people to help make sure they remember to take them.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely. They record their mistakes so that they can learn from them. And they make changes to stop the same sort of mistakes from happening again. The pharmacy team keeps people's information safe and team members understand their role in supporting vulnerable people.

### Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. The SOPs had been implemented on various dates and a small section of SOPs were updated by head office every few months. This helped to spread the workload for pharmacy staff when new SOPs were implemented. SOPs were held electronically, and the pharmacy team members accessed their personal SOP record using their smart phone device. Each SOP had a 'test your understanding' quiz associated with it and store managers were sent a list of the outstanding SOP training so they could address that with the team members.

The pharmacy had recently started using the company's Dispensing Support Pharmacy (DSP) to assemble some of its prescriptions. The DSP had been specifically built as a 'hub' and it used automated processes to dispense large numbers of prescriptions to reduce that workload, and the associated tasks such as stock management, from the pharmacy's that used its services. The pharmacy team had been required to undertake various tasks prior to the start date to ensure the team understood their responsibilities in the new process and to make sure the pharmacy was set up correctly beforehand. Audits had been carried out at different stages to monitor compliance with the new processes, and actions identified and completed.

An electronic near miss record was used with the dispenser involved being responsible for correcting and recording their own error to ensure they learnt from the mistake. The near miss record was saved as a 'favourite' on the pharmacy computer, so it was easily accessible for the team. The near miss report contained notes with each near miss to aid the monthly review process. A pharmacist completed a monthly near miss review and action planning document. The outcome of the review was shared with pharmacy team members and was on display in the dispensary. A newsletter was sent from the pharmacy superintendent every month. The newsletter was read by the members of the pharmacy team and included various clinical governance updates and a case study based on an incident that had happened within the company to share learning. Dispensing incidents were recorded using an online incident reporting system. The pharmacist completed the incident form, and the Store Manager reviewed the incident and added any further action that they thought was required.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A member of the team answered questions related to high-risk over the counter medicine sales correctly. Pharmacy staff were wearing uniforms and name badges which stated their job role.

The complaints procedure was explained in a customer leaflet. The team explained the process for handling a complaint or concern, including how they would speak to the person first and would try to resolve the issue, but would refer to the store manager or head office if the complaint was unresolved. Customers could contact Boots Customer Care at head office by telephone, email, Twitter or Facebook with any feedback about the company or pharmacy.

The pharmacy had up-to-date professional indemnity insurance in place. The responsible pharmacist (RP) notice showed the correct details and was clearly displayed. The RP log was maintained in a record book, and it contained the correct information. Controlled drug (CD) registers also complied with requirements. A CD balance check was completed weekly, and a random balance check matched the balance recorded in the register. A patient returned CD register was used.

Confidential waste was stored separately to general waste and transferred to confidential waste bags for destruction offsite. The pharmacy team members completed an e-learning module on information governance. They had individual NHS Smartcards and confirmed that their passcodes were not shared. The pharmacist had completed level two training on safeguarding. Other members of the pharmacy team completed an e-learning module on safeguarding every year as part of their annual compliance training. The safeguarding procedure and local contact details were available in the dispensary. A safeguarding referral had been made and the details documented on a safeguarding form.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team is working under pressure to meet the current workload. Staffing levels are not always well planned which can lead to a backlog of work, and this creates a difficult working conditions for the team. The pharmacy team members receive the right training for their roles. They work well together in a supportive environment, and they can raise concerns and make suggestions.

### Inspector's evidence

The pharmacy team comprised of two pharmacists working alternate shifts, a pharmacist trainee and two pharmacy advisors. The pharmacy advisors had completed a combined dispensing assistant and medicines counter assistant qualification. There were other roles working within the store such as the store manager, customer advisors and beauty advisors. A delivery service was provided by the area team and covered several different Boots stores. Boots relief pharmacists covered the pharmacists' annual leave. Annual leave was requested in advance using a smart phone app. However, there had been some confusion about who was checking the requests and one of the pharmacy team members had been required to change her annual leave at short notice to ensure there was sufficient cover.

Introduction of the DSP for dispensing repeat prescriptions had affected staffing requirements and had changed the way that the pharmacy team worked. The pharmacy team were busy throughout the inspection and there was a constant queue at the pharmacy counter. The pharmacy services booking list had been printed out for the pharmacist and he had 'flu vaccination appointments at regular intervals, which took him from the dispensary. The team were managing their workload for the day; however, this created a stressful working environment as there was no 'down-time' to catch up. There were two vacancies advertised on the Boots website, so the team was understaffed. The pharmacist was not involved with the staff planning and he did not have access to staff rotas, so it was sometimes difficult for the team to plan daily tasks.

The staffing levels and rotas were reviewed by the store manager. The manager had reviewed the core rotas for the pharmacy in preparation for the introduction of DSP and when people had resigned. Head Office had completed a time and motion study and informed managers of how many hours they should have in each job role based on the amount of pharmacy items, pharmacy services and retail sales they did each week.

All members of the team were required to complete annual mandatory e-learning training. This was audited by head office and the store manager was accountable for ensuring the training was up to date. The team said that they should have regular training time but due to workload pressures they had not been able to do this for a while as they felt guilty leaving the pharmacy whilst it was busy. A range of training materials were available and new modules were advertised and accessible by scanning a Quick Response (QR) code on the poster using a smart phone device. The trainee pharmacist worked closely with his designated supervisor and whilst they attempted to plan his training time into the weekly plans, he often did not take his training time due to the pharmacy being busy. He explained that he felt that he was on-track with his foundation year and would speak to his supervisor, or regional support if he was falling behind or had any concerns.

The team appeared to work well together during the inspection and were observed helping each other and moving onto the healthcare counter when needed. As the pharmacy team members worked closely together, they discussed any near misses, incidents and pharmacy issues on a daily basis within the dispensary and there was a monthly patient safety review briefing. The team used a communication diary to pass on messages between the late and early shifts.

The pharmacy staff said that they could raise any concerns or suggestions to the pharmacists or the store management team. If they had wanted to raise a serious concern, they could contact the area manager or contact a confidential helpline. The pharmacist was observed making himself available to discuss queries with people and giving advice when he handed out prescriptions. Targets were in place for services; the pharmacist explained that he would use his professional judgment to offer services and that his current targets were reasonable and achievable.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy provides a safe, secure and suitable environment for people to receive healthcare services. The pharmacy team has access to a consultation room for services such as vaccinations, and if people want to have a conversation in private.

### Inspector's evidence

The store was smart in appearance and appeared to be well maintained. Maintenance issues were reported to the 'One Number' helpdesk at head office. The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. The dispensary had been extended to create additional space to the side, and they used a lockable area for dispensing compliance packs and for extra prescription storage. Dispensing and checking activities took place on separate areas of the worktops. A large stock room was used for spare retail stock and dispensary consumables.

There was a private soundproof consultation room which was used by the pharmacist during the inspection. The consultation room was professional in appearance. It could not be locked so any equipment needed for services was removed afterwards and stored in the dispensary. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

The pharmacy had an air conditioning system which heated and cooled the pharmacy. The system regulated the air temperature to ensure it was within a suitable and comfortable range. The dispensary was clean and tidy with no slip or trip hazards. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap available.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy manages its services and supplies medicines safely. And people receive advice about their medicines when collecting their prescriptions. The pharmacy gets its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use.

### Inspector's evidence

The pharmacy staff referred people to local services, such as the smoking cessation services, when necessary. They used local knowledge and the internet to support signposting. The pharmacy had step free access from a large free car park and the front door opened automatically, supporting access for wheelchair users and for people with pushchairs.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. A '5-way dispensing stamp' was added to prescriptions to identify which members of the team had been involved in different parts of the dispensing process. A sample of prescriptions checked identified the stamp was being routinely used. And prescriptions had computer generated pharmacist information forms (PIF) attached. These forms allowed the pharmacist to be alerted to any information about the prescription, such as whether it was a new medicine, or a change of dose which supported their clinical assessment of the prescription and any counselling the person needed.

Prescriptions were either dispensed as 'due now', 'due date' or 'DSP'. Due now was used for prescriptions that were to be dispensed immediately and due date was for prescriptions to be dispensed the following day. The details for due date prescriptions were entered into the patient medication record (PMR) and the stock for the prescriptions arrived in the pharmacy the following day. The prescription labels were generated once the barcodes had been scanned and then the prescriptions were assembled. The information for DSP prescription was added to the PMR and accuracy checked and clinically checked by a pharmacist before being submitted to the DSP for assembly. The DSP supplied the pharmacy with sealed bags containing the assembled prescription and the pharmacy team matched the bag to the relevant prescription form. Some prescriptions from the DSP were supplied 'part-dispensed' which meant that some of the medication was not suitable for dispensing at the DSP. This included part-packs, medication that was stored in the fridge or controlled drug cabinet, or was not available as DSP, and the pharmacy dispensed these outstanding items.

Prescriptions containing high risk medicines such as anticoagulants, methotrexate, CDs or valproate containing products, had a coloured, laminated card attached to alert the staff member handing out the prescription that extra counselling or checks were required. This ensured the person received the information they needed about the prescription. The original prescription for any items owing and an owing docket was kept until hand out to allow for any counselling to be given. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and some counselling materials were available. The pharmacy team was unaware of the requirement to add a warning sticker to the dispensing box when they supplied a part-pack of valproate, and a prescription for a lady of child-bearing potential was ready to be collected and did not



have a sticker attached. The pharmacist agreed to review the SOP with the team and to order the stickers.

The pharmacy's computer system included a barcode scanning requirement to support dispensing accuracy and stock management. The product barcode was scanned during the dispensing process and the system would not allow the dispenser to continue if the computer had identified that the barcode did not match the product selected on the computer. The team explained that barcode scanning had vastly reduced the number of near misses due to selection errors.

Multi-compartment compliance packs were supplied to people in the community. A pharmacist had undertaken suitability assessments of people using the service which had resulted in a significant reduction in the number of compliance packs being dispensed at the pharmacy. Following the assessment, people were either supplied with original packs, original packs with medication record charts, or they continued to receive compliance packs if deemed suitable. Some people had decided to move to a different pharmacy when they were not longer offered compliance packs as an option. The prescriptions were requested from the surgeries to allow for any missing items to be queried with the surgery ahead of the intended date of collection or delivery. A sample of dispensed compliance pack prescriptions were seen to have been labelled with descriptions of medication and there was a process in place for managing mid-cycle medication change requests.

A section of the dispensary was date checked weekly and records were kept for date checking. A short-dated item list was kept and medicines due to go out of date in the next few months were recorded. The list was checked in advance and short dated medications were removed from the shelf to ensure they were not supplied. Medicines were not stored in an organised manner on the dispensary shelves and as the stock holding was high this had led to messy and poorly organised shelves. For example, the three strengths of amitriptyline, a 'look alike, sound alike' medicine with a history of being involved in dispensing errors, were mixed in together with no separation between them. The risk of dispensing them incorrectly was mitigated by barcode scanning. All medicines were observed being stored in their original packaging. A range of licenced wholesalers was used to source medicines. Split liquid medicines were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in designated bins. The pharmacy was alerted to drug alerts from head office using the company intranet.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. There were medical fridges used to hold stock medicines and assembled medicines. The medicines in the fridges were stored in an organised manner. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide services safely. And the pharmacy team uses it in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had a range of up-to-date reference sources. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Separate measures were available for preparation of methadone. Screens were not visible to the public as members of the public were not able to access the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

### 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.