Registered pharmacy inspection report

Pharmacy Name: Boots, Bracebridge Drive, Bilborough, NOTTINGHAM, Nottinghamshire, NG8 4PN

Pharmacy reference: 1104565

Type of pharmacy: Community

Date of inspection: 25/08/2022

Pharmacy context

This community pharmacy is situated next door to a health centre. Most of the activity is dispensing NHS prescriptions and selling and giving advice about medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own home. Other services that the pharmacy provides includes substance misuse services, new medicines service and the discharge medicine service. The pharmacy also delivers medicines to people's homes.

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	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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. Its team members have defined roles and accountabilities. The pharmacy manages people's personal information safely. The pharmacy has some procedures to learn from its mistakes. And it generally keeps the records it needs by law. But because it doesn't always record its mistakes it might miss opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were subject to regular review. The SOP folder in the dispensary was a little untidy and the new pharmacy manager was currently checking them to make sure that all staff were up to date. Roles and responsibilities of the team members were identified in the SOPs. The team members wore uniforms and were easily identifiable with name badges. They were seen dispensing prescriptions and selling over-the counter medicines safely.

During dispensing the team mainly used an electronic pharmacist's information form (PIF). PIFs were automatically created by the patients electronic medication record (PMR). The dispensed prescriptions seen with PIF forms had information to highlight key risks to the pharmacist including if it was a new medicine. Most of the dispensed prescriptions seen had a PIF attached, but some did not. The pharmacy also used prompt cards. Cards said if there was a controlled drug (CD) or fridge line, to refer to the pharmacist or that it was a medicine for a child. In addition, the pharmacy used prompt cards for high-risk medicines such as lithium, methotrexate, and warfarin. These cards had questions the person handing out the medicine should ask. Most dispensed prescriptions looked at had the relevant prompt cards attached. Dispensed prescriptions were scanned before being handed out to a person collecting their medicine. This highlighted if the medicines couldn't be supplied because the prescription was no longer valid.

The pharmacy team members investigated, and recorded mistakes made when the wrong medicine had been handed to a person (dispensing errors). Mistakes identified before the medicine had been handed to a person (near misses) were discussed at the time they were found. The pharmacy team aimed to record near misses in an electronic near miss log. But, staff said that this was not being done for all mistakes made. The pharmacist did not know how to access the electronic system but said he thought that the staff member who made the mistake completed the electronic record. The team were supposed to review the near miss log every month to look for trends and patterns and ways to reduce the number of mistakes that were being made. However the last report (which looked comprehensive) had been completed in February 2022. A staff member said that these monthly reviews were not being done because of staffing issues and work pressures.

The pharmacy team maintained the necessary records to support the safe delivery of pharmacy services. These included CD registers, responsible pharmacist (RP) records and private prescription records. The pharmacy kept running balances in all the CD registers, and these were audited against the physical stock on a regular basis. Running balances checked against the physical stock were correct. Private prescription records were held electronically and recorded the required information. The RP notice was visible to people visiting the pharmacy and identified who the RP on duty was.

The pharmacy had up-to-date professional indemnity insurance. The pharmacy had a complaints procedure and an information governance policy. Access to the PMR was password protected. Confidential paperwork was stored and destroyed securely. The pharmacy team understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members adequately manage the day-to-day workload within the pharmacy. The team has a range of experience and skills. And team members are comfortable about raising concerns. But staffing shortages mean that the team members are not always able to make use of the training materials available to them to help keep their knowledge and skills up to date. And the team is not always able to complete some governance tasks as intended.

Inspector's evidence

During the inspection the team coped with the day-to-day workload and worked well together. There was one pharmacist and one pharmacy technician who was an accuracy checking technician (ACT).There were also three dispensers, one of whom worked at the pharmacy regularly, the other two were there providing support due to staff shortages. And a counter assistant who had started a couple of weeks ago. The ACT said that due to staff shortages she was mainly currently carrying out a dispensing role. Staff felt under pressure due to staff shortages and said they had not been able to complete all the clinical governance processes required by Boots because of this. However, recently, some additional staff had been at the pharmacy to provide some support. And the number of prescriptions the pharmacy could send to the remote dispensing hub had been increased. The team were comfortable raising concerns with the area team but felt that support had been a little slow. Team members said they had not had time to complete all their e-learning for the last couple of months or read the latest monthly letter from the superintendent. A team member said that they had not had an appraisal for over a year.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And it has made changes to help keep its team members and people using the pharmacy safe during the pandemic.

Inspector's evidence

The pharmacy had a modern facia to the outside of the building. Inside, the public area was a good size and overall presented a positive image. The dispensary was a good size with enough space and work bench to carry out dispensing tasks safely. But delivery boxes on the floor of the dispensary could present a trip hazard. The dispensary, benches and prescription storage areas were reasonably well-organised.

The pharmacy had air conditioning which ensured the pharmacy was a suitable temperature. Hot and cold water was available. A reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. The pharmacy had processes in place to support safe working during the Covid-19 pandemic. There was a small clear plastic screen at the pharmacy counter which provided re-assurance to both the staff and the customers. There was hand sanitiser available. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers healthcare services which are mainly suitably managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely. And it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the pharmacy can't readily show the action it has taken in response to previous alerts. This makes it harder for the pharmacy to demonstrate how it has protected people.

Inspector's evidence

The pharmacy premises had automatic doors and flat access to provide easy access for people with a disability or with a pushchair to get into the pharmacy. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. The pharmacy delivered medicines to some people. The pharmacist gave advice to people using the pharmacy's services. This included advice when they had a new medicine or if their dose changed. The pharmacist said that he asked people taking warfarin if their INR levels were appropriate and that people taking methotrexate had regular blood tests. He said that he didn't make a record of his interventions. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate.

The pharmacy had a clear flow of dispensing and checking prescriptions. The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label and a quad stamp on the prescription to help identify who was involved in the dispensing, checking, and handing out of prescriptions. Baskets were used during the dispensing process to keep individual people's medicines and prescriptions separate to reduce the risk of error. Team members said that they were a day behind dispensing prescriptions. This meant that more people were coming into the pharmacy asking for their medicines before they had been dispensed. Finding and dispensing these prescriptions took longer and slowed the whole process down further.

Medicines awaiting collection was stored in drawers and patient-identifiable details were not in view of people from the shop floor. Members of the team were observed confirming people's names and addresses before handing out dispensed medicines. Medicines awaiting collection were supposed to be checked on a regular basis to help ensure people collected their medicines, but the team had fallen behind with this task. There were some medicines in the fridge which had been dispensed several months previously. Staff had not had time to check the fridge and take appropriate action. At least one item that had not been supplied was for a patient who used the delivery service. Staff said they would investigate.

The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community who needed help managing their medicines. The pharmacy team had reviewed the service and had undertaken risk assessments with people who had their medicines in these packs. If suitable, some people now received their medicines in the manufacturer's original packaging with a Medicines Administration Record (MAR) chart for support. This chart was a list of all current medicines, with directions and times people should take them. Other people had been assessed as still needing a pack and still received their medicines in multi-compartment compliance packs. The pharmacy had processes to make sure people got their medicines in a timely manner. The compliance packs seen recorded the

colour and shape of the medicine to make it easier for people to identify the medicine. Patient information leaflets (PILs) were routinely sent.

Medicine stock for dispensing was generally stored in an orderly fashion in the dispensary. Opened bottles of liquid medications were marked with the date of opening so that the team could know if they were still suitable to use. The pharmacy had medicinal waste bins for out-of-date stock and patient returned medication. It stored out-of-date and patient-returned CDs separate from in-date stock. The pharmacy kept its CDs securely. The pharmacy team had a system in place to check medicine expiry dates. A check of a small number of medicines didn't find any that were out of date. A short- dated sticker was attached to medicines that were due to expire.

A record of invoices showed that medication was obtained from licensed wholesalers. A team member explained the process for managing drug alerts. But didn't know where the folder was which contained the alerts and a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. The pharmacy had three fridges; the third fridge had recently been acquired from another branch. There were records for the two original fridges which showed the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. There were no records for the third fridge, but the current thermometer readings were within range. A staff member said she would make sure that the fridge was added to the log. The pharmacy's equipment was tested regularly to make sure it was safe and functional.

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.