General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 13, Newbury Retail Park, Pinchington Lane, Newbury, Berkshire, RG14 7HU

Pharmacy reference: 9010416

Type of pharmacy: Community

Date of inspection: 17/10/2022

Pharmacy context

This is a community pharmacy in a large branch of Boots. The Boots store is in a retail park on the outskirts of Newbury. The pharmacy provides a range of services including dispensing prescriptions. It has a selection of over-the-counter medicines and other pharmacy related products for sale. It provides a range of other services, including a flu vaccination service and a pneumonia vaccination service. And it supplies medicines for its substance misuse service.

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	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

The pharmacy has suitable procedures to identify and manage risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team keeps people's private information safe. And it knows how to protect the safety of vulnerable people. But the system it has for responding to people's telephone queries does not allow it to deal with them effectively.

Inspector's evidence

The regular pharmacist explained that since the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. This was partly due to staff shortages. But it was also due to an increase in the number of prescriptions it dispensed because of the temporary closure of other pharmacies nearby. And so, to help manage the workload the pharmacy had reduced its extended opening hours. It did this with the support of line managers and the local NHS team. And it had reduced its opening hours by five hours each day from Monday to Saturday. But it maintained its Sunday opening hours. By reducing its opening hours the pharmacy was able to find enough staff cover as it no longer needed to find team members to cover the hours between 8am and 9am each morning and between 8pm and midnight each evening. When necessary, staff from other branches of Boots worked at the pharmacy and vice-versa. The pharmacy had reduced its range of services during the pandemic. It had done this in part because of a lack of demand and also to concentrate on delivering a safe dispensing service. But since restrictions had lifted it had been able to offer more of its other services. And it was due to launch a travel vaccination service and a chickenpox vaccination service at the end of November.

The team had a system for recording its mistakes. It recorded them electronically and reviewed them monthly. It then reviewed them each month in its patient safety review meetings. The responsible pharmacist (RP) was the regular RP. She described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. This enabled them to reflect and learn. Records showed that the team had been encouraged to do a preliminary accuracy check on what they had dispensed before transferring to the pharmacist or accuracy checking technician (ACT) for a final accuracy check. The team recognised the importance of monitoring and reviewing near misses and errors so that it could learn as much as possible from them. It agreed that records should reflect what the team member had learned and what could be done differently next time to prevent mistakes and promote continued improvement. The pharmacy also received a regular monthly newsletter from the superintendent. The newsletter highlighted areas of risk. And each month it identified common errors and ways to prevent them. It also provided educational information on a specific treatment or condition. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were up to date. And team members had read the SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the pharmacist when they needed her advice and expertise. The RP had placed her RP notice on display where it could be seen by people. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. Each till receipt had information on the back on how people could report their experience of how they had been treated at the pharmacy. People could also give feedback directly to team members. Recent customer comments about the pharmacy's queuing system had resulted in a separate queue for the flu vaccination service.

People had also complained that the pharmacy team did not answer the phone. And team members agreed that work pressures meant that they were often unable to answer it. They had given the local GP practice a pre-paid mobile phone on which to call the pharmacy on a separate line to make sure that their calls did not go unanswered. And the team also communicated regularly with surgeries by email. But the team had raised the issue with head office, to ask for a more tailored answering system so that people could leave a message and were not left feeling that their calls were being ignored. But this had yet to happen, and so people often had to make several phone calls until they were answered, or they had to visit the branch in person. The team was aware that this left people feeling frustrated. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But customer concerns were generally dealt with at the time by the pharmacists or by the store manager or deputy manager as appropriate. The store manager was also a pharmacy adviser, and the deputy manager was a trainee pharmacy adviser. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record and its private prescription records. It had a CD destruction register for patient-returned medicines which was up to date. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy kept records of emergency supplies. And the RP agreed that the records should give a clear explanation for the pharmacist’s decision to supply.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. Confidential paper waste was discarded into separate waste bins. And it was collected periodically to be destroyed appropriately. People’s personal information, including their prescription details, were kept out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to one of the pharmacists. The team could access details for the relevant safeguarding authorities online. And it kept a record of any referrals it made.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy trains its team members for the tasks they carry out. And it effectively supports team members with additional training needs. The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services. But the pharmacy does not satisfactorily manage people's phone calls to the pharmacy.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The regular pharmacist was present along with the store manager who was also a pharmacy adviser (PA). The PA role provided the team member with dispensing assistant training and medicines counter assistant training. Other members of the team present included two further PAs, one of which was working on the counter. Two additional members of the team arrived part-way through the inspection, a PA and a trainee PA. The pharmacy had two full-time RPs who covered the pharmacy's opening hours between them. And they had additional part-time pharmacist support to cover the pharmacy's flu clinics. This helped to provide the service without causing additional disruption to the dispensing service and the pharmacy's other services. The store manager PA and the deputy manager trainee PA were available to help in the pharmacy when it was very busy. And overall, team members were seen to work effectively with one another. The pharmacy had a small team who worked regularly together. The daily workload of prescriptions was in hand. But queues built up from time to time and customers had to wait to be served.

Pharmacists were generally able to make day-to-day professional decisions in the interest of patients. And team members could discuss their concerns with their line managers. They described feeling supported in their work. They had regular reviews about their work performance. And they kept their knowledge up to date through regular online e-learning training modules. Each member of the team was allocated an hour of training time each week. If they had been unable to take it one week, they would try to make it up the next week. The pharmacy supported team members with additional training needs. And it provided them with extra time to complete their training. Pharmacists could make their own professional decisions in the interest of people and did not feel under pressure to meet business or professional targets. But concerns raised about systems for answering the phone had yet to be fully addressed, with people waiting a long time for their call to be answered.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help reduce the risk of the spread of viral infections. And the team keeps its workspace sufficiently tidy and organised.

Inspector's evidence

The Boots store occupied two floors. Its pharmacy was on the ground floor along with its retail space, dispensary and consultation room. On the upper floor it had a room for dispensing multi-compartment compliance packs. And staff facilities and stock rooms. The pharmacy had put measures in place to keep people safe from the transfer of infections. It had put screens up at its medicines counter and at its prescription reception counter. The team had a cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. And it kept the premises clean and tidy.

The pharmacy had a long pharmacy counter running alongside the dispensary and a small waiting area. It kept its pharmacy medicines behind the counter. The dispensary had a countertop where people could hand in or collect their prescriptions. And a separate area for people requiring a flu vaccination. The pharmacists' checking area was on bench space beneath the countertop. And screens along the countertop prevented people from seeing prescriptions on the bench below. The dispensary had workbenches along three sides with storage areas above and below. And it also had a run of pull-out drawers for storing medicines and completed prescriptions awaiting collection. Dispensed items and prescriptions were stored so that people's information was kept out of view. The consultation room was close to the dispensary. It was located at the edge of the shop floor. And it was locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that its services are supplied safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly.

Inspector's evidence

The pharmacy's entrance provided step-free access. And its customer area was free of clutter and unnecessary obstacles. It had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy sent approximately half of its regular repeat prescriptions to a Boots centralised dispensing hub known as a dispensing support pharmacy (DSP). Prescriptions were dispensed at the DSP hub using an automated dispensing system before being checked and bagged. They were then delivered back to the pharmacy in sealed bags for collection or delivery. The system was designed to free up pharmacists' time in-store, so that they could provide other services, manage walk-in and acute prescriptions and multi-compartment compliance pack dispensing. The pharmacy also supplied medicines against private prescriptions, many of which came from its online prescribing service. The prescribing service used both medical and pharmacist independent prescribers.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy managed the service according to a four-week rota. Each month any changes to prescriptions were checked and verified. And people's records updated. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people had the information they needed about their medicines. The pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions she would need to take, and counselling she would give, if it were to be prescribed for someone new.

The pharmacy had been busy with its flu vaccination service since it launched the previous month. And during the inspection the RP continued to provide the vaccination service. The team was responsible for its appointment booking system. People booked their appointments on the pharmacy's online booking system. But the pharmacy blocked out times when they were busy or when they had enough staff so that it could manage the workload. A similar system was to be adopted for the new travel vaccination

service.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It stored its medicines appropriately and in their original containers. And the stock on its shelves was tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the inspector was in date. Short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. Its equipment was generally clean. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room, compliance pack dispensing room and the dispensary. Computers were password protected. Team members had their own smart cards but occasionally they used each other's. People should use their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.