Registered pharmacy inspection report

Pharmacy Name: Boots, Main Entrance, Basildon Hospital, Nethermayne, Basildon, Essex, SS16 5NL

Pharmacy reference: 9012171

Type of pharmacy: Hospital

Date of inspection: 13/11/2024

Pharmacy context

The pharmacy is in a busy NHS hospital near Basildon town centre. It provides NHS outpatient dispensing services and it supplies emergency hormonal contraception against a patient group direction. The people who use the pharmacy are those who have been seen by a clinician at the hospital. The pharmacy also uses its registration to sell pharmacy-only medicines.

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	1.1	Good practice	The pharmacy routinely reviews its standard operating procedures and team members complete competency assessments to show that they had understood them.
		1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce future risks. And the pharmacy's head office has oversight of the incident records.
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	4.3	Good practice	The pharmacy ensures that medicines are fit for their intended purpose. It screens its patient-returned medicines and processes these promptly and ensures that medicines requiring safe storage are managed appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy proactively identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. People can provide feedback about the pharmacy's services. And the pharmacy protects people's personal information well. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and it routinely received updated versions from its head office. They were accessed online and some were available in the pharmacy as hard copies. Team members had to pass a test to show that they had understood the SOPs. And once they had passed the test, they signed to show that they agreed to follow them. Team members knew which tasks should not be undertaken when there was no responsible pharmacist (RP) signed in. And they knew that they should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The pharmacy had a folder containing important information for locum pharmacist working at the pharmacy, including information about the pharmacy's services and the dispensing processes. And team members' roles and responsibilities were specified in the SOPs.

Items in similar packaging or with similar names were separated on shelves where possible to help minimise the chance of the wrong medicine being selected. Team members said that using the dispensing robot helped to minimise the chance of mistakes. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Team members were encouraged to record their own near misses, but this was done by the pharmacist during busier periods. The near miss record was reviewed regularly for any patterns by the patient safety champion. The outcomes from the reviews were discussed openly in the team and learning points were also shared with other pharmacies in the group via the pharmacy's newsletter.

Dispensing errors, where a dispensing mistake had reached a person, were recorded electronically and a root cause analysis was undertaken. Team members undertook reflection, and this was recorded to show that they had learned from their mistake. A recent error had occurred where the wrong type of medicine had been supplied to a person. The two medicines with similar names (Sando K and phosphate sandos) were separated to help minimise the chance of a similar mistake. The pharmacy reported dispensing errors to its head office and the hospital. The pharmacy kept records of interventions where the prescriber had been contacted about a prescription. Team members explained about a recent intervention where the directions on a prescription were not clear.

The pharmacy had current professional indemnity insurance. And the relevant information was recorded when an unlicensed medicine was supplied to a person. The correct responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacy did not supply prescription-only medicines in an emergency without a prescription. People would be signposted to their GP or consultant if needed. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about protecting people’s personal information. And the pharmacy’s data processing notice was clearly displayed in the shop area.

The pharmacy had not received any recent complaints. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy’s website. Team members explained that the pharmacist would attempt to address any complaints and escalate to the pharmacy’s head office if needed. The pharmacy’s customer care telephone number was printed on the reverse of the till receipts. And people could be signposted to the hospital’s Patient Advice and Liaison Service.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And contact details for the safeguarding leads was available in the pharmacy. Team members had completed safeguarding training. They were able to recognise potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. There had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions to ensure people taking medicines are safe. And they can raise concerns to do with the pharmacy.

Inspector's evidence

There were two pharmacists, four trained dispensers and two trainee dispensers working during the inspection. There were contingency arrangements for pharmacist cover if needed and holidays were staggered to ensure that there were enough staff to provide cover. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was seen to be up to date with its dispensing.

Team members appeared confident when speaking with people. They asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. They knew to refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

Team members were provided with ongoing training from the hospital and the pharmacy’s head office. The regularly completed online training modules. And training was monitored by the store manager and the area manager. Team members could complete training in the pharmacy during quieter times or they could access it at home if needed. The pharmacists were aware of the continuing professional development requirement for professional revalidation. They had completed declarations of competence and consultation skills for the emergency hormonal contraception service and had done the associated training. And they felt able to make professional decisions.

The pharmacy did not have regular team meetings due to work patterns, but team members discussed issues as they arose. Team members had appraisals every six months and they felt comfortable to discuss any issues with the pharmacists. And targets were not set for the pharmacy’s services.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access and pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary. The pharmacists could hear conversations at the counter and could intervene when needed. The pharmacy was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines.

The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. And there was seating in the shop area for people waiting for services. There were toilet facilities situated in the hallway outside the front of the pharmacy entrance. These were clean and there were hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well with a clear focus on patient safety. The pharmacy highlights prescriptions for higher-risk medicines and routinely speaks with people when they collect these medicines to ensure that people know how to take these medicines safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds promptly to drug alerts and product recalls, and it keeps records of any action taken. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access from the hospital entrance into the pharmacy through wide entrances. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And there was a counter at a suitable height for wheelchair users.

There was a signed in-date patient group direction available for the emergency hormonal contraceptive service. Prescriptions for higher-risk medicines were highlighted using coloured cards. Prompt questions were printed on the reverse for team members to refer to when handing these items out. And any relevant information about the person's blood test results was kept with the prescription. The RP explained that she routinely checked patient's records if they had been prescribed a higher-risk medicine such as methotrexate or digoxin. And she spoke with people about their medicines when handing them out. Prescriptions for Schedule 3 and 4 CDs were routinely highlighted, and the expiry date of the prescription was clearly recorded on it. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members explained that they checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people but there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist explained that team members routinely checked the patient's hospital record and would refer them to their GP if they needed to be on a PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging.

Hospital pharmacy information sheets were attached to each prescription when they were received. Important information about the prescription or patient were recorded on the sheets so that this was readily available during the dispensing, checking processes and when handing out. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. A quad stamp was printed on prescriptions; staff initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). And this helped ensure that team members knew which prescriptions had been clinically checked. A poster showing the correct checking process was clearly displayed in the dispensary for team members to refer to if needed. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Tubs were used to minimise the risk of medicines being transferred to a different prescription.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, MHRA and the pharmacy's head office. The pharmacy actioned the alerts promptly and it kept a record of any action taken. And it informed the hospital and pharmacy's head office. Stock medicines were stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next year months were highlighted. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging. The pharmacy kept lists of short-dated items, and these were removed from dispensing stock a month before they were due to expire. And this included medicine in the dispensing robot. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. And team members knew what to do if the temperature was found to be outside the acceptable range.

The pharmacy managed patient returned medicines well. People were asked to place returned medicines in a large tray so that team members could check for any CDs or sharps. Goggles and gloves were used to help minimise the risk of needlestick injury to them while handling these medicines. One of the dispensers said that returned CDs were placed in the CD cabinet promptly and waste medicines were put in the pharmaceutical waste bin. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The pharmacy maintained a CD key log to show who was responsible for the CD key throughout the day.

Part-dispensed prescriptions were checked frequently and prescriptions for alternate medicines were requested from prescribers where needed. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy arranged for owed items to be delivered to another Boots pharmacy if a person was not able to return to the pharmacy to collect them. Uncollected prescriptions were checked weekly, and people were sent a text message reminder or called if they had not collected their items after four weeks. Uncollected prescriptions were marked as not dispensed on the computer system and the items were returned to dispensing stock where possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment to help protect people’s personal information.

Inspector's evidence

Up-to-date reference sources were available online. The weighing scales and the shredder were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. Team members had to regularly change their passwords for the computers. The pharmacy’s tills restricted sales of some medicines to prevent people from buying more than the allowed quantity. The dispensing robot could be accessed remotely by engineers. Team members explained that an engineer would usually attend the pharmacy with 24 hours of an issue being reported to them.

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only to help avoid any cross-contamination.

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.