General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 6-8 Market Street, ELY, Cambridgeshire, CB7 4PB

Pharmacy reference: 1029257

Type of pharmacy: Community

Date of inspection: 08/08/2023

Pharmacy context

This community pharmacy is set in the main shopping area of Ely. The pharmacy's main activity is dispensing NHS prescriptions. It also offers a prescription delivery service, New Medicine Service (NMS) checks, seasonal flu vaccinations, emergency hormonal contraception, and blood pressure checks. It supplies medicines to a number of local care homes. And it provides substance misuse treatment and a needle exchange 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	1.2	Good practice	The pharmacy reviews its mistakes regularly and identifies and introduces improvements to make its services safer.
2. Staff	Standards met	2.2	Good practice	The pharmacy's team members are well supported in developing their skills and knowledge. And they get time set aside at work to complete learning.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy proactively follows up about queries and prescriptions for care home residents to make sure they receive their medicines in a timely way.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy’s team members follow clear procedures to provide services safely. The pharmacy generally keeps the records it needs to be law. Its team members record their mistakes and review them regularly, so they can learn and reduce risks. And they understand what they can and cannot do when there is no pharmacist present. The pharmacy keeps people’s private information safe. And its team members know what to do to protect vulnerable people.

Inspector's evidence

Pharmacy services were supported by standard operating procedures (SOPs) which were reviewed regularly. These were now kept in digital format and team members could access through the company’s online portal. There was an audit trail to show that staff had read and understood the most recent versions of these SOPs. The pharmacy team had other tools available to reduce risks in the dispensing process. Pharmacist information forms were attached to each prescription to pass on useful information to other people involved in dispensing prescriptions. Alert cards (laminates) were also attached to some prescriptions to flag those items that needed greater care when handing out to people. Some medicines were dispensed at an off-site hub. This had relieved some of the pressure on this pharmacy brought about by other local pharmacies closing. The pharmacy had a process to make sure information sent to the hub about prescriptions to be dispensed was accurate.

Prescription labels, including those on compliance packs, were initialled at the dispensing and checking stages. A quad stamp was also applied to prescription forms and was initialled to show who had completed a clinical check, who was involved in dispensing and accuracy checking, and who handed out the prepared item. This helped the accuracy checking technicians (ACTs) identify which prescriptions were suitable for them to accuracy check. The team members said that the pharmacist or ACT pointed out any dispensing mistakes the staff had made, and which were picked up during the final check of prescriptions (known as near misses). These events were now recorded online and, along with errors that reached patients, were reviewed as part of a monthly patient safety review process to help identify patterns and trends and establish safer ways of working. Errors which reached patients would be recorded and reported to head office. These incidents had to be reviewed in store and any action points would be recorded as part of that review. Learning points from incidents were also included in the monthly patient safety reviews and were shared with the team through staff huddles. The team members commented that dispensing mistakes involving picking errors had reduced significantly since the introduction of scanning equipment which checked that the correct item had been selected. Near misses were now largely down to quantity errors.

The roles and responsibilities of the team members were clear. When asked, they could confidently explain what they could and couldn’t do in the absence of a responsible pharmacist. They could describe the types of questions to ask when selling medicines and knew which ingredients needed greater care including codeine and pseudoephedrine. They explained that they would refer requests for multiple packs of medicines containing these ingredients to the pharmacist and were also vigilant about people requesting repeat supplies. There was a company complaints procedure. Information about how people could provide feedback about the service they had received was included on every till receipt.

There were appropriate insurance arrangements in place for the services provided. The Responsible Pharmacist (RP) notice correctly showed who the pharmacist in charge was and it was displayed clearly. The RP record and records about controlled drugs (CDs) were complete and running balances were checked regularly. Private prescription records were made electronically in a timely way. But the details about the prescriber were not always captured correctly. Staff said they would ensure the correct details were recorded in future.

The pharmacy protected sensitive information in several ways. Confidential waste was separated and disposed of securely. Staff had completed training packages on protecting people's information and there were written procedures about information governance. Patient medication records were password protected and staff used their own NHS smartcards to access electronic prescriptions. There was no confidential material left on display.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. Staff had read these procedures and had completed safeguarding training relevant to their roles. A training pack sent out to the pharmacy team in July had included an update about emergency hormonal contraception and included a scenario covering potential safeguarding issues.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who have the right skills and training to provide the pharmacy's services safely. They are well-supported in ongoing learning and development, and they have some set-aside time at work to training. There is a strong culture of openness, honesty and learning in the pharmacy and team members can contribute ideas about how to improve how the pharmacy works.

Inspector's evidence

At the time of the inspection a full-time employee pharmacist was providing RP cover. The rest of the team comprised: two part-time accuracy checking technicians, two part-time pharmacy technicians, a full-time trainee pharmacy technician, one part-time and one full-time dispensers, and a medicine counter assistant. The team coped well with their workload during the visit and were observed worked closely together, referring queries to the pharmacist where needed.

The staff had records of training they had completed. The company provided the team with online training materials including updates about over-the-counter medicines and team members got some set-aside time at work to do training. Some of the training modules were considered mandatory to complete to ensure team members kept their knowledge current. Team members were also sent a Professional Standards newsletter regularly from head office which promoted learning from incidents and included professional updates. Alongside other employee pharmacists, the pharmacist was currently undertaking the company's leadership development course.

Team members said they could share suggestions about how to improve the way the pharmacy worked. An example was the trays introduced used in the care home dispensary to track queries and outstanding work. They had reviews with their manager, and these looked at how the member of staff was doing, opportunities to develop their skills, and if they needed any additional support with training. Information was shared amongst the team in a variety of ways including through briefing sheets, team huddles, and handover records. This was particularly important for making sure the service to care homes ran efficiently and important information wasn't lost. There was a staff notice in the dispensary which displayed information about monthly safety reviews and highlighted any learning points from these reviews.

The team said they would feel comfortable raising any concerns with the store manager or pharmacist if needed. There was a helpline for staff if they wanted to raise concerns confidentially. The pharmacist explained that he felt able to exercise his professional judgement when delivering services. And an ACT explained how she could identify those prescriptions which were suitable for her to accuracy check.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are spacious and are suitable for the services the pharmacy provides. The pharmacy team makes sure the premises are kept clean and well-organised to help make its services safer.

Inspector's evidence

There was flat access into the pharmacy and automatic doors so the premises could be accessed by people with wheelchairs, prams or other mobility problems. The pharmacy was equipped with an induction hearing loop. And there was seating for people close to the dispensary. Access to the main dispensary and the care home dispensary was restricted.

Dispensary benches were clear of clutter and various sections of bench and shelving were used for designated purposes, to reduce risks. Pharmacy-only and prescription medicines were kept out of the reach of the public.

A large, well-screened consultation room was located behind the dispensary, and this was used for services and private conversations. The room had access to patient medication records, a sink, and adequate storage for sundries and equipment. There was also a screened area just outside the consultation room that afforded people an alternative place to have a conversation with a member of staff out of view of other people in the shop. Both facilities could accommodate wheelchairs or prams.

All areas of the premises were clean. Staff had access to hygiene facilities. The sink in the dispensary had hot and cold running water. The premises could be secured to prevent unauthorised access. The ambient temperature and lighting during the inspection were suitable for the activities undertaken.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are undertaken safely and effectively. The pharmacy takes particular care when it supplies medicines which may be higher risk including medicines containing valproate. It has good processes to make sure medicines are supplied in a timely and safe way to care homes. To ensure its medicines are suitable for people to take, the pharmacy gets its stock from reputable sources and stores it safely. It responds to safety alerts about medicines or medical devices to protect people's safety and wellbeing.

Inspector's evidence

Information about the services the pharmacy offered were advertised by way of leaflets and posters displayed in the pharmacy. The team members used local knowledge to direct people to other care providers for services that the pharmacy did not offer. They had access to translation services. And could provide larger-print labels on dispensed medicines if needed. There also an induction hearing loop available to assist those with hearing aids. A prescription delivery service was offered to assist some people to access their medicines. Prescription deliveries were recorded so that there was evidence to show medicines had reached the right person.

The storage locations of diabetic medicines and methotrexate were highlighted and were well separated from other medicines to reduce the risk of picking errors. The team understood the information that needed to be provided about pregnancy prevention when supplying sodium valproate. The corresponding patient information leaflets, cards, and alert stickers were available. Alert cards (laminates) were attached to prescriptions for higher-risk medicines and CDs so appropriate counselling and advice could be given to people when they collected their medicines. When the patient medication records highlighted significant interactions between medicines during the dispensing stage, information about these was printed out by dispensers and left for the pharmacist to be able to refer to when completing their clinical or final checks.

The team members knew that prescriptions for CDs were only valid for 28 days and said that prescriptions for all CDs in Schedules 2, 3 and 4 would be highlighted. Examples of these were found when checked.

The pharmacy supplied medicines to residents of around eight local care homes. The medicines were dispensed as original packs and additional supporting information including medication administration records and patient information leaflets were provided. This work was well planned and there were trackers on display in the dedicated dispensary to help make sure all medicines were supplied on time. The team members were able to explain how interim supplies, stock supply issues, unexpected prescriptions and missing items were routinely followed up with care homes and a good audit trail of communications with care home staff was kept and could be referred to in the event of future queries. There were also trays marked for certain tasks on one of the shelves which helped with communication between members of the pharmacy team when team members were not at work.

The pharmacy got its medicines from licensed wholesalers and unlicensed 'specials' were obtained from specials manufacturers. No extemporaneous dispensing was carried out. The pharmacy had

experienced some stock shortages and had liaised with local prescribers to arrange alternative medicines where needed. Medicine stock for dispensing was stored in an orderly fashion in the dispensary. Pharmacy-only medicines were stored out of reach of the public. The pharmacy checked the expiry dates of its stock regularly and kept a record about these checks. Short-dated items were identified to alert staff and reduce the risk of supplying when no longer in date. When a sample of medicines was checked at random, there were no date-expired medicines found. All medicines were kept in appropriately labelled containers. The dates of opening were generally added to the stock bottles of liquid medicines so the staff could assess if the medicines were still suitable to dispense. Out-of-date medicines and patient-returned medicines were transferred to designated bins. These were stored away from other medicine stock and were disposed of through licensed waste contractors.

There were processes followed to denature CDs before disposal. Appropriate arrangements were in place for storing Controlled Drugs (CD) and access to the CD cabinets was well-controlled. There was enough storage capacity for medicines requiring cold storage. Fridge temperatures were checked regularly to make sure they remained within the safe range for storing temperature-sensitive medicines. The records seen were within the appropriate range of between 2 and 8 degrees Celsius.

The pharmacy was informed about drug recalls and safety alerts through company communications and there was a process in place to make sure the pharmacy responded to these promptly.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It keeps its equipment clean. And it has processes to make sure its equipment is safe and effective to use.

Inspector's evidence

The pharmacy had measuring equipment of a suitable standard to use when dispensing and providing other services. All medicine measures were clean, and some were marked for specific use to prevent cross-contamination. The meter used for checking people’s blood pressure was replaced periodically, most recently in November 2022. There was suitable equipment for disposing of sharps waste and clinical waste arising from vaccination services. And there was adrenaline and syringes readily available in the event of anaphylactic reactions.

The pharmacy had a range of up-to-date reference sources available for providing advice and clinical checks. All electrical equipment appeared to be in good working order and was tested regularly.

Patient medication records were stored electronically and access to these was password protected. NHS smartcards to access summary care records and electronic prescriptions were not shared. Screens containing sensitive information were not visible to the public. The staff had access to cordless phones and could move to quiet areas of the pharmacy to make phone calls out of earshot of waiting customers.

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.