General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 12 Mill Steet Mall, Grosvenor Centre, MACCLESFIELD, Cheshire, SK11 6AJ

Pharmacy reference: 1029650

Type of pharmacy: Community

Date of inspection: 19/08/2024

Pharmacy context

The pharmacy is in a large retail store inside an indoor shopping centre in Macclesfield, Cheshire. It mainly dispenses NHS prescriptions, including for people living in care homes. It supplies some medicines in multi-compartment compliance packs to help people living at home take their medicines properly. It provides a range of services, including NHS Pharmacy First and NHS hypertension case finding service. It has a paid-for medicines delivery 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 team is good at recording and regularly reviewing errors to learn from them. And they take effective action to reduce the risk of errors happening again.
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 written procedures relevant to its services to help team members provide them safely and effectively. And it is good at updating its written procedures when it changes its ways of working so team members know the right way to complete tasks. It mostly keeps accurate records as required by law. And it keeps people's private information secure. Team members are good at recording and learning from mistakes. And they have the knowledge and confidence to help support vulnerable people.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) were accessible online and through individual team member's training records. These included for dispensing, services, controlled drug (CD) management and responsible pharmacist (RP) regulations. The SOPs checked were due for review in 2025 and 2026. SOPs were released monthly, including for new services and more recently for updates in the dispensing process. Team members were prompted to read the SOPs and they then completed multiple choice questions to assess their understanding of the process. Team members training records were stored online and were up to date, with SOPs due to be read that month in progress or completed by all the team. On the day of the inspection, the pharmacy had changed its process for dispensing. This meant the pharmacist completed the clinical check and an accuracy check of data inputted before dispensing. And the dispenser then completed the dispensing and bagging process using barcode scanning. The team had read the updated SOP and received training before implementation. The correct Responsible Pharmacist (RP) notice was displayed, although it was not easy to see from the retail area. Team members were aware of their roles and responsibilities, including how the changes in the dispensing process affected their roles and the tasks they completed. They provided advice to people at the pharmacy counter and on the telephone within their competence and they referred to the pharmacist when required. They understood what tasks could and couldn't be completed before a pharmacist signed in as RP.

The pharmacy recorded its near miss errors electronically. These were mistakes identified during the dispensing process. The team recorded near miss errors each month, and these included for the dispensing of care home prescriptions, which was a significant amount of the workload in the pharmacy. The records of near miss errors included details of what happened, for example recently the most common mistake appeared to be dispensing the incorrect quantity. The team were part way through rearranging the medicines in the dispensary downstairs, as it had been recognised the untidiness of the shelves with more than one open pack increased the risk of mistakes. Team members recorded dispensing incidents, which were mistakes identified after the person had received their medicines. They recorded details of what happened and what actions had been taken to reduce the risk of a similar incident occurring. There was a recent error when more than the prescribed quantity of a CD had been supplied, and this had been thoroughly investigated. The patient safety champion used the information from near miss errors and dispensing incidents to produce monthly patient safety reports, including a separate one for dispensing to care homes. The patient safety champion worked across the two areas of dispensing and shared any common trends. The findings, with clear improvement actions, were discussed in team huddles and displayed on notice boards for all team members to read. The pharmacy had a complaints procedure and a way to record complaints electronically. A team member explained their role in handling complaints and when they would

escalate matters to the RP or assistant manager. The team asked people to feedback on the pharmacy's services by handing out business cards with details of how to provide feedback, although there had been little feedback received about the pharmacy recently.

The pharmacy had current professional indemnity insurance. From a sample seen, most of the records required by law were completed correctly, including CD register entries and RP records. Of the electronic private prescription entries seen, the team had entered the incorrect prescriber on one and the incorrect date the prescription was written on another. The team checked the quantity of CDs in stock against the balance in the register weekly and recorded these checks. For two CDs checked, the physical stock was correct against the register balance.

The pharmacy displayed a privacy notice, and it had a leaflet for people to pick up with information about how people's personal information was held on the pharmacy's computer system. Team members completed online training about information governance and were confident on how to protect people's privacy and confidential information. They kept people's confidential information in the downstairs dispensary, visible only to pharmacy staff. The doors to the two other dispensing areas upstairs were accessed using a key code to protect people's private information stored there. They separated confidential waste, and stored it securely until a third-party contractor collected it. The pharmacist working on the day of the inspection had completed safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE), to level 2 within the last year. A dispenser, who had completed online training, was confident recognising signs of potential abuse and referring to the RP. The pharmacy had a safeguarding policy, displayed a chaperone notice, and advertised the consultation room as a safe space, which supported people experiencing domestic abuse. The pharmacist was aware of what to do should someone need to access this service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs team members with the right skills and knowledge to manage the workload safely. And they support each other to complete the workload, including during periods of change. Team members feel confident to suggest ideas to improve ways of working and to raise professional concerns should they need to. The pharmacy supports its team members to learn and to complete their qualification training.

Inspector's evidence

The pharmacy was open seven days a week. On weekdays, there were often two pharmacists on duty, one of whom worked in the upstairs dispensing area, where the team managed the dispensing for people living in care homes. On the day of the inspection there was one pharmacist on duty. They worked regularly at the pharmacy two days a week. The rest of the week was covered with different pharmacists, often employed relief pharmacists. There was not always consistency of pharmacists working, which made it more difficult for planning workload. The team was unsure why there was no second pharmacist working on the day of the inspection, and team members were seen bringing down additional workload from the upstairs dispensing area. This included tasks such as completing clinical checks on prescriptions and checking the multi-compartment compliance packs. There was no working telephone line between the downstairs dispensary and the two dispensing areas upstairs, so this made it more difficult for the RP to communicate with the team working upstairs and fulfil their RP role. This was the first day of change to dispensing processes in the downstairs dispensary and there appeared to be additional pressure to complete the workload. The team, including the assistant manager, were seen supporting each other to manage queries and dispensing and checking prescriptions. Also, it had not been possible to open the pharmacy the day before, on the Sunday, as there had been no pharmacist available. Although there was a backlog of work, team members were working calmly and prioritising more urgent prescriptions. The RP continued to provide services such as the NHS Pharmacy First Service and NHS Hypertension finding service, for people who needed them.

There were in total fourteen team members, who worked across the three dispensary areas. The pharmacy provided services for approximately twenty care homes, which was a considerable proportion of the workload. In this area on the day of the inspection, there was a team member who co-ordinated the care home business work, a pharmacy technician working in an accuracy checking role (ACPT), a team member dedicated to processing prescriptions and a dispenser. In the morning, this dispenser had completed the workload associated with the multi-compartment compliance pack service for people living in the community. A second ACPT was on annual leave. In the downstairs dispensary there was a trainee dispenser helping people access services at the pharmacy counter, a full time newly qualified dispenser and the RP. The assistant manager helped with the workload in the downstairs dispensing area as needed. There was a queue for much of the inspection and the inspector waited around five minutes before being seen, due to people waiting for prescriptions, advice, and sale of over-the-counter medicines. Team members asked questions about people’s symptoms before recommending over-the-counter medicines and providing advice. They described how they monitored sales of medicines liable for misuse, including for medicines containing codeine. A team member explained how they used their professional judgement when making sales and would refer people to speak with the pharmacist if they asked for repeat purchases of codeine-containing medicines.

There was a longstanding and experienced team working in the upstairs dispensing areas, who worked well together. They had informal huddles to discuss workload and ways to improve the safety and effectiveness of working. Following a change in pharmacy procedures, they had identified they were not working efficiently by dispensing medicines for people across two separate rooms. They changed where they dispensed these medicines and during the inspection it was seen to work well. The team knew how to raise professional concerns and there was a whistleblowing policy. Team members felt supported to complete their accredited qualification training courses. There was ongoing online training for all team members to complete each month, recently this had been mostly reading SOPs. They had opportunities to complete training during working hours, although some team members preferred to complete it at home.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And they are appropriately clean, secure, and maintained to an adequate standard. There is a large, bright consultation room where people access services and have confidential conversations with team members.

Inspector's evidence

The pharmacy premises were adequately clean, secure, and hygienic. They were over three floors, within a large Boots retail store. In-person services and sales of medicines were accessed on the ground floor at the back of the retail store, which was clearly signposted. This part of the premises had tensor barriers across access points, which were pulled across when the pharmacy was closed. Team members prevented unauthorised access to the dispensary and medicines stored behind the pharmacy counter. There was a full height wall across part of the dispensary, which allowed privacy for dispensing. The layout allowed the pharmacist to supervise the sale of medicines at the pharmacy counter. There was enough space for dispensing and storage of medicines. The team made effective use of the shelving above the benches to store prescriptions and medicines awaiting checking, to help avoid clutter on the benches. These shelves were full of prescriptions and medicines, stored neatly in tubs, waiting to be checked. And there were some prescriptions awaiting checking stored in tubs on the dispensing benches. The dispensary floor was clear.

There were two upstairs pharmacy areas, one on the second floor used for dispensing of medicines in multi-compartment compliance packs and another more spacious area over several rooms, on the third floor. This was where the team processed and assembled medicines for people living in care homes. Both areas had a good amount of bench space for dispensing and shelving for storing medicines. The benches were clean and uncluttered. There was a despatch area on the third floor, where the team stored medicines awaiting delivery to the care homes. The pharmacy used the store’s lift to move medicines and consumables to and from the upstairs pharmacy areas. Team members didn’t travel in this lift, as reportedly it was not reliable, and maintenance were called out regularly to fix it.

The pharmacy team had access to staff facilities. There was hot and cold running water for handwashing and the preparation of medicines. But the team had been informed after a refit not to use the water in the dispensing area downstairs for preparation of medicines. This had been reported recently for investigation. As there was drinkable water in the consultation room, they did some preparation of liquid medicines there. Lighting was bright and the ambient temperature was suitable for working and storage of medicines. There was a spacious and tidy consultation room, which was soundproofed for confidential conversations and suitable for the provision of services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to help support people living in the local community and in care homes. It manages and delivers these services safely. And it has suitable systems in place, so people receive their medicines when they need them. The pharmacy obtains, stores, and manages its medicines appropriately.

Inspector's evidence

There was parking in a multi-storey car park with a lift and the store had level access from the indoor shopping centre. There was clear signage for the pharmacy in the store. It had practice leaflets available, which advertised its services and opening hours. And there were healthcare leaflets and posters displayed to help people access services. The pharmacy provided the NHS Pharmacy First Service. There were up-to-date patient group directions (PGDs) for the service's treatment pathways. And a check list on the pharmacy counter to help team members have conversations with people about treatments available. The pharmacy delivered medicines to people's home for a one-off or yearly charge. And they delivered medicines to care homes according to contracts with the care homes. The team entered details of the deliveries on to an electronic platform, which meant there was a record of people's deliveries. The delivery drivers used handheld devices to scan when they had delivered the medicines to complete the audit trail.

The pharmacy had safeguards to help manage risks in the dispensing process. This included using plastic tubs to hold people's prescriptions and medicines together. They initialled the dispensed by and checked by boxes on dispensing labels to keep an audit trail of which team members had been involved. Team members used a handheld device to scan a barcode on the person's medicine bag, before handing it out to people. The handheld device prompted team members to provide advice and to complete a series of patient-safety questions before handing out. These included questions relating to the pregnancy prevention programme in people taking valproate. And the team had knowledge about the requirement to dispense valproate in original manufacturer's packs. The updated dispensing process introduced the day of the inspection meant the pharmacist completed the clinical check prior to the prescription being released for dispensing. And as it was a new process for the dispenser to use barcode scanning to complete the dispensing and bagging process, the pharmacist was completing a further accuracy check for approximately two weeks on all prescriptions.

The pharmacy team dispensed medicines into multi-compartment compliance packs to help people take their medicines at the right time. The process was organised, with prescriptions ordered in advance, so there was time to resolve any queries. Team members completed a progress log to provide an audit trail of completion of the workload. The dispensing workload was up to date and the packs were ready in advance of people needing them. There were record cards, neatly completed, detailing people's current medication, dosage, and administration times. Any change to people's medicines was documented. The record cards were used alongside prescriptions throughout the dispensing and checking process. The dispenser annotated the packs with descriptions of what the medicines looked like so they could be identified in case of queries.

The team dispensed medicines for care homes on a four-weekly cycle to balance out the workload, and the details were displayed on a white board for easy reference. The workload was tracked to ensure

prescriptions were received from the care home with enough time to plan and complete the workload for when people needed their medicines. The care home teams ordered prescriptions every four weeks, and the pharmacy sent a reminder when this was due to be completed. Once the pharmacy received the prescriptions, a report was produced for the care home of the medicines they were going to receive that month. This provided a double check for the care home teams and meant they could re-order any missing items. The team used a shared mailbox and actively encouraged the care home staff to email their queries so there was a record of the queries made and it helped reduce the telephone calls received. There was a direct telephone line for care home staff to contact the pharmacy team. The team explained how they assessed prescriptions received for urgency, for example prescriptions for antibiotics, pain killers and end-of-life care medicines were dispensed after the agreed cut-off time if needed. This helped ensure people received their medicines the same day.

The pharmacy obtained medicines from recognised wholesalers. Pharmacy-only (P) medicines were displayed behind the pharmacy counter, to help the pharmacist supervise sales. CDs were held securely, and the team kept out-of-date CDs separated from in-date stock. There were disposal bins for expired and patient-returned stock. Team members used a date checking matrix to record checks on medicine expiry dates, and this was mostly up to date, with a few omissions in July. Team members were tidying and rearranging the dispensary shelves and they had made an additional check on expiry dates of the medicines during this process. A sample of medicines checked across all pharmacy areas were found to be in date. The stock held for dispensing multi-compartment compliance packs and for care homes was managed well. The team annotated liquid medicines with the date of opening and used stickers to highlight stock close to its expiry date. The pharmacy used medical fridges, and there were records of daily temperature checks showing them to be within the required range. The temperatures were in range during the inspection. The pharmacy team received an electronic notification of safety alerts and medicine recalls. They printed them off and the pharmacist signed when the required action had been taken. The assistant manager received a separate notification so they could check compliance. The assistant manager gave a recent example of action taken following an alert regarding topiramate.

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 facilities and equipment to suitably protect people's private information.

Inspector's evidence

The pharmacy had the equipment it needed, including a range of clean, glass measuring cylinders used for dispensing. And it had two blood pressure monitors to support the pharmacy's NHS hypertension case finding service, which the pharmacist confirmed were replaced by head office automatically. And it had sharps bins to use for vaccination services. The multi-compartment compliance packs used were single use and fit for purpose. The team had access to reference resources, the internet and company resources for up-to-date information on services and for clinical information. The internet access was reportedly not always reliable and sometimes impacted on access to online resources, for example training. This was seen during the inspection.

The pharmacy stored dispensed medicines awaiting collection on shelves behind the handout area. This prevented people in the retail area seeing confidential information on prescriptions and on name and address labels on bags. Computer screens were positioned so unauthorised people couldn't see any confidential information. Computers were password protected, and use of NHS Smart cards meant access to people's medical records was controlled. And there was a cordless telephone for team members to use downstairs to help keep conversations private.

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.