General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 28 Hull Road, Anlaby, HULL, North Humberside, HU10 6UA

Pharmacy reference: 1032090

Type of pharmacy: Community

Date of inspection: 11/09/2024

Pharmacy context

This community pharmacy is in a village in the suburbs of Hull, in East Yorkshire. The pharmacy's main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy offers a range of NHS consultation services including the New Medicine Service (NMS), blood pressure check service and Pharmacy First service. It supplies some medicines to people in multi-compartment compliance packs, to support them in remembering to take their medicines. And it delivers some 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	1.4	Good practice	Pharmacy team members demonstrate how they use feedback from people using the pharmacy to inform and monitor actions to improve the safety and quality of the pharmacy services.
2. Staff	Standards met	2.5	Good practice	The pharmacy actively engages with its team members and encourages them to share their ideas and provide feedback through a number of workplace initiatives. It listens to the feedback from its team members and uses this to inform how it operates.
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 effectively identifies and manages the risks for providing its services. It encourages people to provide feedback about their experiences. And it shows how it uses this feedback to inform and monitor change. The pharmacy keeps its records as required by law. And it holds people's confidential information securely. Pharmacy team members act to reduce risk following the mistakes they make during the dispensing process. And they know how to identify and act on concerns to help keep vulnerable people safe from harm.

Inspector's evidence

The pharmacy had a comprehensive range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. The SOPs were reviewed on a two-year rolling cycle or sooner if there was an identified change in process. Pharmacy team members completed learning which included an assessment following them reading individual SOPs to confirm they had understood them. The responsible pharmacist (RP) on duty was a locum pharmacist. They explained they were required to confirm their understanding of the pharmacy's SOPs before booking shifts for the company. Team members were knowledgeable about the tasks they undertook and demonstrated safe working practices when completing tasks. A team member explained what tasks would not take place in the event the RP took absence from the pharmacy. Pharmacy team members completed a series of daily checks. They explained how these checks of record keeping, cleanliness standards and information sharing supporting them in managing workflow effectively and in ensuring team members were working safely.

Pharmacy team members demonstrated how they used functions within the patient medication record (PMR) system to help reduce risk when dispensing medicines. These functions included scanning medicines to ensure team members had selected the correct medicine to assemble and team members acknowledging safety prompts to inform a series of checks during the dispensing process. The pharmacy had a process for managing mistakes made and identified during the dispensing process, known as near misses. Team members acted to reduce risk by recording most of their mistakes. The pharmacy team recorded the mistakes it identified following the supply of a medicine, known as dispensing incidents. Its investigation process included reviewing the root cause of a mistake and identifying changes required to the dispensing process to help reduce risk. For example, physically highlighting prescriptions to draw extra attention to the RP when the PMR system would not scan a medicine. The team analysed reports following mistakes to help them identify patterns and actions required to reduce risk. Recent records from monthly patient safety reviews showed a repetitive action of the need for team members to slow down whilst dispensing. A discussion highlighted the benefits of keeping identified actions under review to help inform when further steps may be needed to reduce the risk of mistakes occurring. The team also used safety information provided by its head office team to explore case studies about patient safety and to inform its approach to managing risk.

The pharmacy advertised how people could provide feedback about their experience at the pharmacy. Pharmacy team members had a clear understanding of how to manage feedback and how to provide details to people if they wished to escalate their concern. Most members of the pharmacy team had transferred from another pharmacy within the last year due to the other pharmacy closing. They had

worked together as a team to reflect on feedback provided by people. And they had used this information to inform a local action plan to help improve people's experiences. For example, they were vigilant in monitoring activity in the public area of the pharmacy and team members made themselves available to serve people in a timely manner when a queue built up at the prescription reception counter. All pharmacy team members completed mandatory safeguarding learning to help protect vulnerable people. They showed good insight into the types of concerns that would require reporting with support from the manager and RP. The pharmacy advertised its consultation room as a safe space. And its team members had a clear understanding of what to do should a person attend the pharmacy requiring access to the safe space.

The pharmacy kept personal identifiable information in staff-only areas. Its team members completed annual mandatory learning about the importance of keeping confidential information secure. They demonstrated how they segregated confidential waste and disposed of this securely following the pharmacy's procedures. The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of the RP record, the private prescription register, specials records and the controlled drug (CD) register were checked and complied with legal requirements. The pharmacy maintained running balances in the CD register, and it completed full balance checks of physical stock against the register balance frequently. Random physical balance checks of CDs conducted during the inspection matched with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of people with the right skills and knowledge to provide pharmacy services. It supports the learning and development needs of its team members through regular reviews. The pharmacy has clear leadership which provides a supportive environment for team members. It provides a number of options for its team members to provide feedback at work. And it listens to their feedback and uses it to inform positive change. Pharmacy team members are happy and motivated in their roles, and they work together well. They show how they use information shared in team briefings to inform the safe delivery of the pharmacy's services.

Inspector's evidence

The RP was working their first shift at the pharmacy. They were working alongside the pharmacy manager (a qualified dispenser) and four other qualified dispensers. The pharmacy also employed a regular full-time pharmacist, and two other qualified dispensers. Locum pharmacists covered the regular pharmacist's leave and days off. Other team members reported working flexibly to support cover during periods of both planned and unplanned leave. The pharmacy could request additional support from other local company-owned pharmacies and from an area relief team if it was struggling to maintain appropriate staffing levels during periods of leave.

The team was up to date with its workload and team members were observed working well together when completing tasks. There was a strong emphasis on rotating tasks between team members to ensure all team members felt competent when completing different tasks to support the safe and effective running of the pharmacy. And a good morale between all team members had formed within the last year. The pharmacy manager demonstrated how they had used an action plan to help prioritise areas for improvement they had identified. Team members contributed to this by providing feedback and they worked well together to ensure they completed the actions required. The RP on duty engaged well with the team, they had not been informed of specific targets the pharmacy had for providing its services. The team identified people that were eligible for services, such as blood pressure checks during the dispensing process. And team members promoted these services to people when handing out bags of assembled medicines.

Pharmacy team members engaged in a structured appraisal system to support their learning and development at work. The pharmacy manager was enrolled on a level four management course. They had taken a break from their learning to support the team in working through the action plan. And had recently recommenced their course. Team members received training time at work and explained how they used this to complete mandatory e-learning relevant to their roles and to complete learning for the pharmacy's SOPs. The pharmacy received regular reports which monitored the team's completion of learning to support all team members in keeping their knowledge and skills up to date. Pharmacy team members used both informal and formal briefings to share information and learning with each other. This included engaging in patient safety reviews and feeding back any concerns openly. A large noticeboard between the dispensary and staff break room provided a wealth of helpful information for team members such as the latest patient safety review, details of the most recent staff survey and information about performance against targets.

Team members were encouraged to share their ideas. Several team members discussed how their feedback was listened to and used to inform change. For example, the use of workspace and storage space within the dispensary had been adapted to support them in working safely and effectively. The pharmacy had a whistle blowing policy. Team members could also provide feedback through a local employee forum representative, and they provided examples of how they fed back through this channel. Team members knew how to access the pharmacy's employee assistance programme. This included access to a confidential support service for team members. The pharmacy also asked team members to complete periodic staff surveys. Team members engaged in this process and felt that sharing their thoughts helped to inform how the company operated its pharmacies.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriately clean, secure, and maintained. People visiting the pharmacy are given the option to speak to a member of the team in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. Pharmacy team members understood how to report maintenance concerns. There was one ongoing maintenance concern about the smell coming from a drain in the staff-only area of the premises. Some trees had recently been removed from near to the drain very recently and the team were monitoring if this had made any difference to the issue. The manager confirmed their plan for escalating the concern if it was not resolved. The pharmacy was clean and organised throughout. The public area consisted of a sizeable retail space fitted with wide spaced aisles. And it provided seating for people waiting. The pharmacy's private consultation room was clearly signposted. It was small but offered a clean and professional environment for people accessing consultation services. And the RP was seen inviting people into the room when undertaking a consultation.

The team managed space in the dispensary effectively. There were dedicated areas for completing different stages of the dispensing process, and for completing stock management tasks. The team used designated shelving above work benches to hold tubs of assembled items waiting to be checked. This space was not needed during the inspection as the team was up to date with its workload. Rooms off the dispensary led to staff break and toilet facilities. Lighting was adequate throughout the premises and air conditioning helped to maintain a suitable temperature all year round. Pharmacy team members had access to sinks equipped with antibacterial hand wash, sanitiser gel and paper towels.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible for people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. Pharmacy team members apply regular checks to ensure medicines are safe to supply. They identify higher-risk medicines and provide helpful information to people to support them in taking these medicines safely. And they generally keep effective audit trails to support them in answering any queries that may arise when providing pharmacy services.

Inspector's evidence

People accessed the pharmacy from street level. It advertised some details of the services it provided and clearly displayed its opening times. The pharmacy had supportive information available to its pharmacists providing NHS consultations. This information included current patient group directions (PGDs) for supplying medicines as part of a consultation service, copies of service specifications and consultation pathways for pharmacists to refer to. Team members knew how to signpost people to other healthcare providers or pharmacies if the pharmacy was unable to provide a service. They had contact information for other local company-owned pharmacies and explained how they would contact them to ensure a service or medicine was available prior to signposting people to a pharmacy.

The pharmacy kept pharmacy (P) medicines behind a counter. Team members were observed asking appropriate questions when people requested to purchase these medicines. And they understood the importance of monitoring requests for higher-risk P medicines and some higher-risk general sales list medicines that were liable to abuse. A team member explained how they would refer repeat requests for these medicines to the RP. And provided examples of the RP declining sales and referring people to their GP for support when a sale was deemed not appropriate. The team made a series of checks during the dispensing process when supplying higher-risk medicines requiring ongoing monitoring to people. It did this through prompts on its PMR system and on its handheld scanning devices and by printing 'Pharmacist Information Forms' (PIFs) to support RPs in making interventions when supplying medicines. The prompts included information such as details of the expiry date of CD prescriptions and counselling requirements. And the handheld scanning devices required team members to confirm they had conducted the checks required when handing out these medicines. The team used a notes section of the PMR record to record the interventions it made when supplying medicines. For example, to record checks of people's blood test results when supplying warfarin. Team members generated a PIF for each prescription dispensed. The PIF highlighted key information to support the clinical check of prescriptions and the accuracy check of medicines. But a sample of assembled medicine found PIFs were not always attached to prescriptions up until the point of handout to inform some counselling checks not covered by the prompts displayed on the handheld scanning devices. For example, informing a person of the need to supply a short-dated medicine. The team was aware of the requirements of medicines subject to Pregnancy Prevention Programmes (PPPs). They discussed how they supplied these medicines, and the RP took the opportunity to discuss recently updated information involving the supply of valproate to men and how they used this information to support them in providing counselling to people.

Pharmacy team members used tubs when dispensing medicines. This separated people's prescriptions from others to avoid items being mixed up. They signed the 'dispensed by' and 'checked by' boxes on

medicine labels to provide an audit trail of their role within the dispensing process. They completed separate audit trails on prescription forms to identify which team member had completed specific tasks during the dispensing process. But a sample of prescriptions found the accuracy checking section of this audit trail was not always completed. The pharmacy used some automated processes within its PMR system to dispense some medicines in manufacturer's original packaging. This involved team members entering data from prescription forms into the PMR and an accuracy check of the data and clinical check of the prescription by a pharmacist. This generated a stock order for the items on the prescription. Once the team received this stock, they used barcode scanning technology to dispense the medicine. The PMR flagged any interventions required by a pharmacist during this dispensing process for a final accuracy check.

The pharmacy conducted assessments to help identify if supplying a medicine in a multi-compartment compliance pack would be of benefit to a person prior to supplying a medicine in this way. The team held individual patient records for each compliance pack it dispensed. It recorded changes to medication regimens on these records. But it did not always detach one section of a duplicate pad it used to record these changes to ensure a copy of the communication about the change was kept with the patient record. There were no assembled compliance packs available to check during the inspection. Team members explained they provided descriptions of the medicines on medicine labels attached to the compliance packs and they stated they provided patient information leaflets at the beginning of each four-week cycle when supplying medicines in this way.

The pharmacy kept prescriptions for the medicines it could not immediately supply to people. Its team members dispensed from the prescription when later supplying these medicines. They made regular checks with wholesalers about medicines availability, and they informed people of long-term supply problems, to support them in contacting their GP ahead of them running out of medicine. The pharmacy maintained an electronic audit trail of the medicines it sent through its delivery service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner with most medicines held in the manufacturer's original packaging. It stored CDs safely in secure cabinets. And it held medicines requiring cold storage in pharmaceutical fridges. It kept records of the operating temperature range of the fridges and these records showed medicines were stored between the required temperature range of two and eight degrees Celsius. The team completed regular checks of its medicines, and it recorded these checks. It highlighted medicines with short expiry dates and it clearly marked liquid medicines with details of their opening date and shortened expiry date of any medicine left in the bottle. The pharmacy had medicine waste receptacles to support it in disposing of patient-returned and out-of-date medicines safely. The pharmacy received medicine alerts and drug recalls electronically and team members demonstrated timely checks of these alerts to ensure medicines remained safe to supply to people.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It makes regular checks to ensure its equipment and facilities remain safe to use. And its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to a wide range of digital reference resources via an online subscription service. The RP explained they carried a copy of a widely used professional reference resource with them to support them in their work. Pharmacy team members accessed people's medication record records through using personal NHS smart cards and password protected computers. Information displayed on the pharmacy's computer monitors was protected from unauthorised view. The pharmacy stored bags of assembled medicines safely and in a way which meant details on bag labels and prescription forms could not be read from the public area. They used a cordless telephone handset when speaking on the telephone. This meant they could move to suitable areas of the pharmacy to protect people's confidentiality when speaking to them over the telephone.

Equipment to support the team in completing dispensing tasks was readily available. This included clean counting and measuring equipment with separate equipment clearly identifiable and available for counting and measuring higher-risk medicines separately. Equipment to support consultation services was stored neatly in the consultation room. All equipment was recognised manufacturers and the team cleaned and checked equipment between use. The pharmacy's electrical equipment was annotated to show it was regularly checked to ensure it was in safe working order.

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.