General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 139 Newland Avenue, HULL, North Humberside, HU5 2ES

Pharmacy reference: 1032115

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

This community pharmacy is on a busy road in a large suburb of Hull close to Hull University. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartmental compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And it provides supplies of emergency hormonal contraception.

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	N/A	N/A	N/A
2. Staff	Good practice	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The pharmacy supports team members who identify areas of practice they wish to develop. So, they can keep their skills and knowledge up-to-date.
		2.5	Good practice	The team members support each other in their day-to-day work. They identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.
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 identifies and manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has appropriate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team may miss opportunities to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy used quiz sheets to test the team's knowledge of a selection of SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. The team member involved recorded their error. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The team reviewed these records each month to spot patterns and make changes to processes. The team had used recent reviews to remind each other of the importance of checking the person's name and address on the prescription. To ensure it matched the details on the electronic patient record (PMR). The pharmacy completed an electronic report for dispensing errors. These were errors that were identified after the person had received their medicines.

The pharmacy undertook a monthly patient safety review. The trainee pharmacy technician with support from the pharmacy manager led on this. And shared the results with the team members. The pharmacy displayed the outcome from the latest review in the dispensary for the team to refer to. The pharmacy had recently upgraded the computer system. This had resulted in a change of procedure for the team members. The team scanned the bar code on the dispensed product to see if it matched the prescription. The team noticed since the introduction of this process the number of picking errors had reduced. The latest patient safety review reminded the team to always scan the medicines, so the system could pick up any errors. This review also reminded the team to double check the quantities of medication dispensed. And to always double check the label generated against the prescription. So, errors could be spotted. The pharmacy had labels that directed the team to select and speak the product selected. The team attached these labels to shelves holding items that looked and sounded alike (LASA). The pharmacy displayed laminate cards next to the computer terminals listing the LASA medicines for the team to refer to. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The

pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy had a leaflet informing people about the confidential data it kept. And it displayed a notice about the fair processing of data. The team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding policy and a locally produced guide on how to raise a safeguarding concern. And pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has team members with the qualifications and skills to support the pharmacy's services. The team members identify factors contributing to increased workload and work pressures. And they help and support each other to improve their efficiency. So, they can reduce their workload pressure and help provide safe and effective delivery of services. The pharmacy is good at providing team members with opportunities to develop their knowledge and skills. And it gives team members regular feedback on their performance. So, they can keep their skills and knowledge up to date.

Inspector's evidence

A full-time pharmacist covered most of the opening hours. Boots relief pharmacists provided support when required. The pharmacy team consisted of a part-time trainee pharmacy technician, two full-time dispensers, one who was the pharmacy manger and two part-time dispensers. At the time of the inspection the full-time pharmacist, the pharmacy manager, two dispensers and a relief dispenser were on duty. One of the dispensers had worked at another Boots pharmacy in a dispensary that only dispensed prescriptions for care homes. So, they had asked for experience in a pharmacy that enabled them to develop their skills when communicating directly with people and when selling over-the-counter products. The team was supporting the dispenser by providing opportunities to work on the pharmacy counter.

The pharmacy was close to Hull University, so the prescription numbers varied according to term dates. And many prescriptions were presented at the pharmacy as walk-in prescriptions rather than repeat prescriptions. The pharmacy manager recognised the impact this had on the team's workload. And had adapted the Boots model of daily tasks to support the team. The pharmacy held regular team huddles. The team members used the huddles to plan their work, discuss any issues and share information sent from Boots head office.

The pharmacy provided extra training through e-learning modules. The team members had protected time to complete the training. The pharmacy provided performance reviews to the team members. So, they had a chance to receive feedback and discuss development needs. The pharmacy manager used the company model day concept which listed the daily tasks each team should complete when discussing personal development opportunities with individual team members. The pharmacy manager had spent time with the trainee pharmacy technician to identify gaps in their knowledge and skills. And as a result, allocated tasks from the model day concept to the trainee technician. The pharmacy manager had also given the trainee technician the responsibility of the monthly patient safety review as part of their training. The pharmacy had a template for team members to record their observations about each other when they were providing pharmacy services. The template included the advice the team member had given to people using the pharmacy. And the feedback from the colleague observing.

Team members could suggest changes to processes or new ideas of working. And the pharmacy had a whistleblowing policy. The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequate for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The dispensary was small and narrow with limited bench space available. The team managed this by keeping the area uncluttered. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. And they manage the pharmacy services well. The pharmacy team members keep records of prescription requests and deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and mostly manages medicines appropriately.

Inspector's evidence

The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And it used a small section of the retail area to promote healthy living advice. The current focus was on advice and support for people who wanted to give up smoking. The team wore name badges detailing their role. The pharmacy provided the flu vaccination service and emergency hormonal contraception (EHC) against up-to-date patient group directions (PGDs). These provided the pharmacist with the legal authority to administer the vaccine and supply the EHC medicines. The flu vaccination service was popular. People liked the convenience of the service. The pharmacy had adrenaline injections available in case someone had an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartmental compliance packs to help around 27 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The pharmacist usually completed a clinical check of the prescription before one of the dispensers generated the labels. This provided an extra step to identify any medicine changes and query them with the GP team. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The team stored completed packs on dedicated shelves in baskets labelled with the person’s name. The pharmacy had a collection document for the team members to record when they had supplied the packs. The team recorded details such as the date of handing the packs out. And obtained a signature from the person collecting the packs. The team referred to this when queries arose. The pharmacy sometimes received information from the teams at the local hospitals about people’s medicines after they had been discharged. The team checked the information for changes or new items.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. The pharmacy provided a repeat prescription ordering service. The pharmacy team usually ordered the prescriptions a week before supply. The team often experienced delays with receiving the prescriptions. So, ordering the prescriptions in advance gave the team time to chase up missing prescriptions, order stock and dispense the prescription. The pharmacy had a system that provided separate stock for the repeat prescription service. So, when the medicines arrived the team knew which items were for these prescriptions.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. So, they had a prompt to check what they had picked. The pharmacy team used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person obtained from the electronic medication record (PMR) during labelling. These forms included dose changes or new medication. The PIF stayed with the prescription until the team supplied the medication. So, everyone could refer to the information captured on the PIF. The team used the PIF to record medicines that looked and sounded alike (LASAs), as these were often linked to errors. The team members used this as a prompt to check what they had picked. Following a few errors with the quantities of medicines dispensed the team was asked to use the PIF to record the quantity. So, everyone involved in dispensing the prescription could check the quantity of medicine. The pharmacy team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. And the team had separated the valproate products from other medicines. The team used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person. For example, their latest blood test results.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include the fridge items. The pharmacy had stickers for the team to record the date CD prescriptions had to be supplied by. To ensure the supply was within the 28-day legal limit. But the team did not use this for all CDs that had this legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a quad stamp. The pharmacy used this as an audit trail of who had clinically checked, accuracy checked, dispensed and handed out the medication. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 21 October 2019. The team used a 'caution short dated stock' sticker with the expiry date written on to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 06 September 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had scanning equipment installed to meet the requirements of the Falsified Medicines Directive (FMD). And it was waiting for a computer upgrade to enable the team to scan FMD compliant packs. The team had not received any training and most team members were not aware of FMD. The pharmacy obtained medication from several reputable sources. And received alerts about medicines

and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in 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.