General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 43 Friargate, Freshney Place, GRIMSBY, South Humberside, DN31 1EL

Pharmacy reference: 1032470

Type of pharmacy: Community

Date of inspection: 12/02/2024

Pharmacy context

This community pharmacy is in a shopping centre close to Grimsby town centre. It provides a range of services including dispensing NHS prescriptions and the NHS Pharmacy First service. The pharmacy supplies medicines to people living in several care homes in the area. And it supplies several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. The pharmacy also provides a private travel clinic.

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	N/A	N/A	N/A
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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns. Team members respond competently when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) which provided team members with information to support the safe and effective delivery of its services. They accessed the SOPs via an online platform and answered a few questions to confirm they had read and understood them. The pharmacy manager was alerted to new SOPs and changes made to existing SOPs and monitored the team's reading of the SOPs. A recent SOP read by the team covered the bar code scanning technology used by team members to support the accuracy check of dispensed medication. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. Records of these errors known as near miss errors were made after the pharmacist or the accuracy checking pharmacy technician (ACPT) discussed it with the team member involved. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident so they could learn from it. And were aware of the actions taken to prevent such errors from happening. For example, after one dispensing incident the team identified that the names of the two medicines involved were similar which had led to the wrong medication being dispensed. So, they separated the two medicines to reduce the risk of picking and dispensing the wrong one. Team members were also reminded to keep the work benches free of clutter and to complete one job at a time.

The pharmacy undertook a monthly review of the near miss errors and dispensing incidents. And the outcome was shared with team members who discussed the changes they could make to prevent future errors. The ACPT led the review, but the pharmacy manager was training some team members to complete this process to support the ACPT. The latest review was displayed for all team members to refer to. The pharmacy's electronic patient medication record (PMR) system used bar code scanning technology for team members to scan the bar code on the dispensed product. And see if it matched the prescription. Team members reported this had reduced the number of errors involving the wrong medication being dispensed. And most near miss errors involved the wrong quantity of medication especially when partial packs of a medication were used. This had been highlighted in a recent review and team members were advised to carefully count the medication dispensed. The pharmacy had a procedure for handling complaints raised by people using its services. And the company's online platform provided a section on frequently asked questions and details on how people could provide feedback.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The

pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. And had been signed by the pharmacists to show they had read them, understood them and would follow them.

Team members had completed training on the General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacy displayed information on how people's confidential data was protected and it displayed a notice about the fair processing of data. The pharmacy had safeguarding guidance for the team to follow. And team members had completed training relevant to their roles. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They are encouraged to raise concerns and make suggestions to ensure the efficient delivery of pharmacy services. Team members have some opportunities to receive feedback and complete training so they can suitably develop their knowledge.

Inspector's evidence

A full-time pharmacist and regular locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time trainee pharmacy technicians, one who was also the pharmacy manager, one part-time ACPT, five part-time dispensers and two part-time healthcare assistants. To support the pharmacists with the delivery of services, particularly the NHS Pharmacy First service, the pharmacy was recruiting for another ACPT. At the time of the inspection most team members were on duty. Amongst the team numbers was a dedicated team and manager for the care home service. Two part-time nurses supported the pharmacists with the delivery of the private travel service.

Team members worked very well together and supported each other. All team members were trained or being trained on how to undertake key tasks. And a daily rota ensured there was always one team member working at the pharmacy counter, so people were not kept waiting. Team members who usually worked in other areas of the pharmacy such as the care home team helped colleagues in the main dispensary when required. The pharmacy had trialled a new rota system that involved team members regularly changing, throughout the day, the role they were responsible for. However, team members fed back that this system did not work and was not helping with the efficient delivery of services, so the original rota was re-introduced.

Team members used company online training modules to keep their knowledge up to date. And they had protected time at work to complete the training. A training matrix recorded when team members had completed the training which was monitored by the pharmacy manager. Team members read the newsletter sent from Boots Professional Standards team that provided information such as new services. And signed the newsletters to show that they had read and understood them. In preparation for the launch of the NHS Pharmacy First service the team had received a new set of SOPs. And training modules including an evening event that involved role-play scenarios for team members to complete. The pharmacists had completed additional training reflecting their specific roles such as assessing the conditions listed within the service. The pharmacy manager had created a folder to hold the SOPs and accompanying training materials for the Pharmacy First service and the recently introduced PMR automated checking system. So, team members could readily access the information when needed.

The team held regular meetings and used a communication platform and a communications book to record information for all team members to be aware of. Separate meetings were held between the teams in the main dispensary and the care home teams. Formal feedback on their performance was limited to certain team members. But all team members regularly received informal feedback from the pharmacy manager and store manager. The pharmacy manager, soon after starting in post, held one-to-one sessions with each team member. So, they could get to know each team member, understand their role and previous experience. And discuss any opportunities to help them develop their knowledge and skills.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. It has good facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. They used two large upstairs rooms for dispensing and checking multi-compartment compliance packs. And for the care homes service. These provided plenty of space for the team to work and were away from the distractions of the busy retail area.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had two large, soundproof consultation rooms which were used for private conversations with people and when providing services. And there was a separate, cordoned off area that provided privacy to people receiving their medication as a supervised dose. There was restricted public access to the pharmacy during the main store's opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via the main store entrance through an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And displayed a GPhC poster explaining what people could expect from the pharmacy. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the correct product was supplied. And they knew when to refer requests to the pharmacist. The NHS Pharmacy First service was popular, and the team had seen many people present at the pharmacy since its launch. Team members supported the pharmacists by completing the referral form with the person, so the pharmacist had the information available to refer to when speaking to the person. People used the company's website to book appointments for the pharmacy's private travel clinic. On the days the service was operating and supported by the nursing team the pharmacist completed a governance checklist. This recorded that the service was operating in accordance with regulatory standards.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. The team ordered prescriptions several days before supply to allow time to deal with issues such as missing items. And they recorded the completion of each stage of dispensing and checking the packs. Each person had a record listing their current medication and dose times which team members referred to when dispensing and checking the packs. They recorded the descriptions of the products within the packs but did not always supply the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs but did not always have all the information about their medicines. Occasionally the NHS discharge medicines service was used by the local hospital to send the pharmacy team details of the medication a person had been discharged with. Team members used this to identify new medicines and changes to the person's existing medication. And when contacting the person's GP to request prescriptions.

The pharmacy supplied medicines to several care homes of varying sizes. To manage the workload the team divided the processing of the prescriptions across the month. And usually started the process three weeks before the start of the care home's next cycle. Team members checked the prescriptions received against the list of medicines ordered by the care home team to identify missing items or changes. Any queries regarding the medication ordered were usually sent to the care home team by email. So, there was an audit trail for the pharmacy team and care home teams to refer to. For example, the team advised the care home team when a medication was not available and that the prescriber had been asked for an alternate medication. The pharmacy supplied the medication several days before the start of the next cycle to give the care home team time to check the supply. The team placed dispensed medication ready for delivery in a dedicated area so it could be checked with the delivery drivers when they came to collect the medicines. The pharmacy had a cut-off time for deliveries to ensure the drivers could complete their deliveries. But urgent deliveries could be arranged

for example when an antibiotic had been prescribed.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The prepared doses were stored securely and people's doses separated to reduce the risk of selecting the wrong one. The pharmacist completed a final check of the pre-prepared dose at the time the person presented. And asked the person for their date of birth and the dose they were expecting. This helped to reduce the risk of the person receiving the wrong dose. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the new rules requiring valproate to be supplied in the manufacturer's original outer packaging. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and reported no-one prescribed valproate met the criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Plastic tubs were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the ACPT to complete their check. There was also an audit trail on the prescription to capture who had downloaded the electronic prescription, completed the clinical and accuracy checks and handed out the medication. The recently introduced bar code scanning technology for accuracy checking a prescription was not working on the day of the inspection so could not be demonstrated.
People received a text message from the pharmacy advising them when their prescription was ready to collect. The pharmacy used clear bags to hold dispensed CDs and medicines stored in the fridge so the team, and the person collecting the medication, could check the supply. And it had CD and fridge cards which team members attached to bags and prescriptions to remind them when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. A record of the delivery of medicines to people was kept for the team to refer to when queries arose.

The pharmacy obtained its medication from reputable sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. They checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were clearly marked to prompt the team to check the medicine was still in date. A list of short-dated medicines was kept for the team to refer to each month and remove any medicines that had reached the expiry date. No out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. They also recorded the date the opened medication should be used by. The team checked and recorded fridge temperatures each day and a sample of these records showed the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And the team used appropriate denaturing kits to destroy CDs. The pharmacy 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 its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. And two fridges to hold medicines requiring storage at these temperatures. One fridge had a glass door which enabled team members to view the medicines inside without prolong opening of the door. The pharmacy regularly completed safety checks on its electrical equipment.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. And some team members wore headphones that enabled them to easily contact colleagues in other areas such as the care home room. They stored completed prescriptions away from public view and they held other private information in the dispensary and rear areas which had restricted public access.

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.