General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Units 12/15, The Gates Shopping Centre, Mealhouse Lane, BOLTON, Lancashire, BL1 1DF

Pharmacy reference: 1033187

Type of pharmacy: Community

Date of inspection: 28/06/2022

Pharmacy context

This pharmacy is located at the rear of a Boots store in a shopping centre in the centre of the town. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies a large number of care homes and it dispenses private prescriptions from the Boots online prescribing service. A large number of NHS prescriptions are sent to a different pharmacy in the company to be assembled.

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 employs a range of review and monitoring mechanisms for the services it provides to help it identify and manage any risks. And the pharmacy team records and analyses adverse dispensing incidents to identify learning points which it incorporates into day-to-day practice to help manage future risks.
		1.4	Good practice	The pharmacy actively encourages people who use the pharmacy services to provide feedback or raise concerns. This feedback is shared with the pharmacy team to drive improvments in services.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their role and the pharmacy effectively supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team actively promotes services which reflect the needs of the local community to help improve their health and wellbeing.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively manages the risks associated with its services to ensure it keeps people safe. It asks its customers for their views and feedback, and this is usually very positive. Members of the pharmacy team work to professional standards and they are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and act to help stop the same sort of mistakes from happening again. The team generally completes all the records that it needs to by law and team members know how to protect children and vulnerable adults. The pharmacy has written procedures on keeping people's private information safe, but the design of the dispensary could be improved to prevent people's confidential information being seen.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided. SOPs were available in different formats including digital versions. Members of the pharmacy team confirmed electronically via the e-learning system that they had read and accepted the SOPs and completed an assessment to test their understanding of the SOP. The store manager could view a dashboard which showed which members of the pharmacy team had read which SOPs and who had any outstanding. Roles and responsibilities were set out in SOPs and the team members were performing duties which were in line with their role. They were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

The pharmacy team recorded, reviewed and managed dispensing incidents and near misses via regular patient safety reviews. Near miss incident logs were used to record incidents, and there was a separate log used in the care home room. There was a notice board in the dispensary where learnings from the previous month's patient safety review were displayed. There was a notice with key points to prevent a delay in therapy for patients ,which included information on triaging prescriptions and communication. There was also a notice reminding the team about the patient behind the prescription to promote person-centred care. The pharmacist superintendent's (SI) office sent out a 'Professional Standards Bulletin' every couple of months which staff read and signed. It included case studies with points for reflection and root cause analysis. It also highlighted risks which had been identified and suggested ways to minimise these. There were regional patient safety meetings where people from other branches met and discussed incidents and shared learnings, which were then cascaded to the rest of the pharmacy team. Look-alike and sound-alike drugs 'LASAs' were highlighted with 'select with care' and 'say aloud' stickers. Following a near miss the two strengths of Celluvisc eye drops had been separated to avoid a re-occurrence. Lists of the common LASA's were displayed at several locations in the dispensary and care home room. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. There was a new patient medication record (PMR) system which included a safety feature whereby the bar codes on medicines were scanned, and if the incorrect medicine or strength had been selected, the dispenser would be alerted . If the medicine did not have a bar code 'NB' would be added to the pharmacist information form (PIF) so the pharmacist would know to be extra vigilant and carry out an extra check on the accuracy. This was because the dispenser had not been able to scan the medicine to verify it. One of the dispensers explained that quantity errors were the main form of errors since the introduction of the new PMR system. They confirmed they were comfortable discussing and reporting errors.

A pharmacist's log was completed daily and weekly by the RP. The fridge temperature, RP notice, CD key security and records were checked as part of this. A weekly clinical governance checklist was carried out by the store manager or delegated to one of the assistant managers. This included a check on the pharmacy log, confidential information and staffing levels. This was recorded electronically and included any actions required for compliance. The area manager and head office could view and monitor these records. A notice showing 'model day' was on display and duties that were required to be completed each day were ticked off when completed. Weekly and monthly duties were also listed on the notice. There were notices displayed in the consultation room explaining the symptoms and treatment of fainting, seizures and anaphylaxis and the process to follow after a needle-stick injury or accidental exposure to blood. This helped the team to manage the risks associated with the flu vaccination service.

'About this pharmacy' leaflets were on display which gave details of the complaints procedure and encouraged people using the pharmacy's services to give suggestions or feedback. 'Tell us how we did cards' were available for people to provide feedback on their experience. The store manager received this feedback on their mobile phone and ensured it was shared with the team. Any negative feedback would be investigated but recent feedback had all been very positive. One of the dispensers had received such good feedback over the year that they had been given a regional award, for always providing a warm welcome to people, understanding them and going the extra mile. The store manager explained that the dispenser was often asked for by name and was mentioned in at least two positive responses every week.

Professional indemnity insurance was in place. Private prescription and emergency supplies records were maintained electronically, but the prescriber details were missing or incorrect on some of the prescriptions, which might lead to confusion in the event of a problem or query. RP record was generally in order but had been pre-completed with the time the RP would cease their duties, which might risk the accuracy of the record. The store manager confirmed that they would remind the team of the importance of completing these records accurately. The CD register was appropriately maintained. Records of CD running balances were kept and these were regularly audited. One CD balance was checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

Members of the pharmacy team had completed training on information governance which included confidentiality. Information on confidentiality was in the 'About this pharmacy' leaflet. There was a risk that customers standing at the front dispensary could see prescriptions in the process of being assembled. The pharmacy team managed the risk of breaching patient confidentiality by asking other patients to stand back and never left prescriptions unattended on the bench. Verbal consent was received before sending people's prescriptions to the dispensing support pharmacy (DSP) to be assembled. This consent this was not always recorded, which might be a problem in the case of a complaint or query. People who did not wish their prescription to be sent to the DSP could opt out and a note of this would be made on their records. Confidential waste was collected in designated bags, which were sealed when full and sent to head office for destruction. A dispenser correctly described the difference between confidential and general waste. The delivery driver knew what it meant to maintain patient confidentiality and confirmed they had read written procedures on this. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR).

The pharmacists and pharmacy technician had completed level two training on safeguarding children and vulnerable adults, and other staff had completed level one training on e-learning. The delivery driver and a dispenser both explained that they would voice any safeguarding concerns to the pharmacist. There was a notice on display in the dispensary and in the care home room with the safeguarding policy and details of who to contact in the local, area. The pharmacy had a chaperone policy and this was highlighted to patients. The pharmacy team were aware of the 'Safe Space'

initiative, where pharmacies were providing a safe space for victims of domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members are well trained and they work effectively together. The pharmacy encourages them to keep their skills up to date and supports their development. They are enthusiastic and knowledgeable. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance to help them improve. The pharmacy has enough team members to manage its workload safely. It enables the team members to use their professional judgement to benefit people who use the pharmacy's services.

Inspector's evidence

There was a pharmacist, an NVQ2 qualified dispenser (or equivalent) and a trainee dispenser in the main pharmacy on the ground floor. There was a pharmacist, five NVQ2 qualified dispensers (or equivalent) and a delivery driver in the care home room. The staffing level was adequate for the volume of work during the inspection and the teams were observed working collaboratively with each other. Planned absences were managed to ensure adequate staffing and skill mix in the two departments. Staff were multiskilled and could be transferred between the two teams, and they could increase their working hours when necessary, depending on the workload. The store manager and one of the assistant managers were qualified dispensers and the other assistant manager was a trainee dispenser, so all three could provide support in the pharmacy. And staff could be transferred from a neighbouring branch if necessary. Both the pharmacists worked regularly at the pharmacy and there was a third regular pharmacist. This had helped to ensure consistent pharmacist cover during the pandemic and the pharmacy had not made any unplanned closures. On two days a week there were two pharmacists present in the pharmacy. There was an accuracy checking technician (ACT) on the pharmacy team and a second ACT had just been recruited. This enabled the pharmacists to spend more time on their clinical roles and services.

The staff used the e-learning system to ensure their training was up to date and undertook assessments to check learning. Mandatory training was completed on this system, such as health and safety, fire and manual handling, and the team were also able to access a wide range of professional training resources. Pharmacy team members carrying out the services had completed appropriate training and appeared confident and competent in their roles. One member of the team explained they were given training time for the mandatory training, but sometime struggled to find time to complete their dispensing course, due to workload pressures.

Team members had daily and weekly meetings where performance against targets and other issues were discussed. Patient safety was usually included at these meetings. One member of the team said that they received informal feedback from the pharmacists, but they hadn't taken part in a formal procedure to discuss their performance and development. They confirmed that they would be comfortable raising concerns with one of the pharmacists or the store manager. They also said they would be comfortable discussing concerns with the area manager, who they described as very approachable, and who visited the pharmacy every couple of weeks. There was a whistleblowing policy and a notice on display explaining this. There was a notice in the staff room asking staff to report unethical behaviour with the relevant contact details.

One of the pharmacists confirmed that they were empowered to exercise their professional judgement and said they could comply with their own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because they felt it was inappropriate. The pharmacy had several targets for pharmacy services. These were closely monitored but the pharmacist didn't ever feel pressure to achieve them. They said that targets were there to improve patient care, such as the NHS hypertension case-finding service, which had led to some important interventions for people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment for people to receive healthcare services. It has a private consultation room that enables it to provide people with the opportunity to receive services in private and have confidential conversations.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean, spacious, well maintained and in a good state of repair. The retail area was free from obstructions and professional in appearance. Cleaning rotas were used to ensure all areas of the pharmacy were regularly cleaned. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue.

There was a large, dedicated care home room on one of the upper floors of the building. It was on one side of a large stockroom. It was fitted with a digital lock and a dispenser confirmed it was usually locked when nobody was working there to prevent unauthorised access. Staff facilities were on the first floor and included a staff room with a kitchen area, WCs and wash hand basins. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available.

There was a consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which it makes available to people with different needs. The pharmacy team members work well to promote services to help improve people's health and wellbeing. And they engage people in quality conversations about their health. Services are generally well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including people with mobility difficulties and wheelchair users. There was a hearing loop in the pharmacy and a sign indicating this. There was support for people with disabilities such as providing alternative forms of medicine labelling or reminder charts. Services provided by the pharmacy were advertised in leaflets and posters. Team members were clear what services were offered and where to signpost people to a service not offered. Some staff were multilingual understanding and speaking Urdu, Punjabi, Gujarati and Arabic, which helped the non-English speaking people from the Asian community. There was a wide range of healthy living material and booklets offering support and advice on various conditions. For example, diabetes UK and living with dementia. The pharmacy was actively promoting the NHS hypertension case-finding service which had resulted in several people being referred to their GPs with undiagnosed hypertension or irregular heartbeat. The pharmacist's successes in promoting and carrying out pharmacy services had led her to win an area award.

The pharmacy offered a managed prescription ordering service. People indicated their requirements a month in advance when they collected their medication. Requirements were checked again at handout to reduce stockpiling and medicine wastage. There was also a digital process where patients ordered their medication themselves online. A large proportion of these prescriptions were sent to the DSP to be assembled. A member of the pharmacy team entered the details of the prescription onto the PMR system which had a safeguard to prevent the prescription details being sent to the DSP until the pharmacist had carried out the appropriate checks. A red plastic envelope was used to indicate that there had been a query with the clinical check, and these prescriptions were put on one side until the pharmacist had resolved the query. If a person came to collect the prescription before it had been returned from the DSP then the prescriptions could be dispensed in the pharmacy, and the medicines returned to stock when they arrived from the DSP. This was to help prevent delays to people receiving their medication.

There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient on the delivery driver's handheld device. Any special arrangements were available for the delivery driver to see on the device. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. Care home deliveries and deliveries containing CDs were entered onto designated forms which were returned to the pharmacy after the deliveries had been made.

Space was adequate in the dispensary and the work-flow was organised into separate areas. The front

of the dispensary was used for small uncomplicated prescriptions and the back for larger prescriptions and CDs. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. A stamp was completed on the prescription showing who had entered the data (labelled), dispensed, clinically checked, accuracy checked and handed out the prescription. Tubs were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. PIFs and laminated care labels were used to highlight that a fridge line, CD or new medicine had been prescribed or if any other counselling was required. For example, warfarin and methotrexate prescriptions. Counselling points were printed on the back of the relevant care cards to remind staff of the important points. Prescriptions containing valproate were noted on the PIF and the team were aware of the valproate pregnancy prevention programme. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

The pharmacy provided multi-compartment compliance aid packs for some people who lived independently in the community. The service was well organised with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed. Medicine descriptions were included on the labels to enable identification of the individual medicines. Packaging leaflets were included so people were able to easily access additional information about their medicines. Disposable equipment was used to prevent contamination. There was a SOP for new people requesting a compliance aid pack. An assessment was made by the pharmacist as to the appropriateness of a pack or if other adjustments might be more appropriate to their needs. Other adjustments considered were dispensing medicines in bottles without child resistant lids, for patients who found opening original packs difficult, and supplying people with Medicine administration records (MAR) charts.

The pharmacy also supplied a large number of care homes. There was a care home manager who was a qualified dispenser. They managed the team who worked in the care home room and liaised with the various care homes, responding to any feedback received. The medicines were supplied to all the care homes in original packs with MAR charts. When prescriptions were received, they were matched to the request made by the care home and any discrepancies chased up. There was a log made of missing items and queries, and a care home communication book was used to record any messages. Specific care service PIFs were completed for every patient to ensure all the relevant information was available for the pharmacist when carrying out their clinical and accuracy check.

The pharmacy used a combination of patient group directions (PGDs) and private prescriptions for their private services. The pharmacist carrying out a consultation for antimalarials entered all the patient's details and travel arrangements onto the computer and a private prescription was generated. The prescription contained the GPhC number and signature of a pharmacist independent prescriber but the prescription appeared in a couple of minutes, which might not be a sufficient time for a thorough review of the individual questionnaire by the prescriber, which might increase risk.

The pharmacy dispensed prescriptions from the Boots online private prescription service. This was treated as a fulfilment service by the pharmacy team. No checks were made at the point of collection that the patient had entered the correct details on the online questionnaire, although the pharmacist did ask if there had been any changes since completing the questionnaire. One of the pharmacists stated that they would contact the prescriber if the person collecting a prescription for a weight loss medication was clearly underweight.

One of the pharmacy team explained what questions they asked when making a medicine sale. The mnemonic 'CARE' was used to remind staff of the importance of Counselling, Advising, Reading packaging and Escalating if necessary, when customers asked for specific medicines by name. They used

the WWHAM questions when they were asked for general advice and to recommend a product. The team understood what action to take if they suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in four CD cabinets which were securely fixed to the floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. A CD key lock was used to track the location of the CD keys. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

Alerts and recalls were received from head office via messages on the intranet and from the NHS area team. These were read and acted on by the pharmacist or member of the pharmacy team and then filed for future reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. For example, the electronic medicines British National Formulary (BNF). One of the pharmacists said they used an App on their mobile phone to access the electronic BNF, as this was more convenient that using the printed copy. There were three clean medical fridges. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. Any problems with equipment were reported to head office. There was a selection of clean liquid measures with British Standard and crown marks. The pharmacy also had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.