General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 10 Peel Avenue, The Trafford Centre, MANCHESTER, Lancashire, M17 8BD

Pharmacy reference: 1033628

Type of pharmacy: Community

Date of inspection: 26/11/2019

Pharmacy context

This pharmacy is situated in an out of town shopping mall, serving people from across Manchester. It mainly supplies NHS prescription medicines and it orders prescriptions on behalf of people. It also provides other NHS services such as emergency hormonal contraception (EHC) and influenza vaccinations. Its other services include hair retention and meningitis B, chicken pox and travel vaccinations.

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	2.1	Good practice	Staff do not feel pressurised when working and complete tasks properly and effectively in advance of deadlines. And the pharmacy responds effectively to changes in its staffing levels so that they remain appropriate.
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 generally manages its risks well. It provides the pharmacy team with written instructions to help make sure it provides safe services. The team records and reviews its mistakes so that it can learn from them. It keeps people's information secure. And the team understands its role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy had written procedures that it regularly reviewed. These covered the safe dispensing of medicines, responsible pharmacist (RP) regulations and controlled drugs (CDs). Records indicated that staff had read and understood each procedure. And the resident pharmacists counter-signed these records when they observed each team member consistently adhering to the procedures. Staff also had their knowledge of procedures regularly tested. So, each team member had a clear understanding of the procedures that were relevant to their role and responsibilities.

The pharmacy recently had a new patient medication record (PMR) system installed, which required medications selected for dispensing to be scanned to confirm they were correct. According to the pharmacy's records this had helped to reduce the number of near misses that reached the accuracy checker.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each supply of prescription medication. And it assisted with investigating and managing mistakes. Team members discussed and recorded any mistakes they identified when dispensing medicines and addressed them separately. The resident pharmacists reviewed these records each month and shared the key learning points with the rest of the team. However, staff usually did not record the reason why they thought they had made each mistake. So, they could miss additional opportunities to learn and mitigate against risks in the dispensing process. The team also regularly discussed the patient safety case studies that the superintendent office had issued, which could help to increase their vigilance.

The pharmacy overall received positive feedback across several key areas in its last published patient satisfaction survey taken between April 2018 and March 2019. Publicly displayed leaflets gave info on how to make a complaint, and the team had read the pharmacy's complaint procedures, so it could effectively respond to them.

The pharmacy had professional indemnity insurance for the services it provided. The RP, who was a resident pharmacist, prominently displayed their RP notice, so people could identify them. The pharmacy maintained the records required by law for the RP, private prescription and CD transactions. The team checked the CD running balances regularly, which helped to detect any discrepancies at an early stage. It also maintained its records for CD destructions, flu, chicken pox, meningitis B and travel vaccinations, EHC, hair retention and prophylactic travel treatments.

All team members had completed the pharmacy's annual data protection training. They used passwords to protect access to people's electronic data, disposed of confidential material securely, and used their own security card to access people's NHS electronic data. The team regularly completed monthly data protection audits. Publicly displayed leaflets referenced the pharmacy's privacy notice and how to access it online. The pharmacy had obtained people's written consent to access their

information in relation to the prescription ordering, flu, chicken pox, meningitis B vaccination and hair retention services. The pharmacy recorded that it had obtained people's verbal consent to access their information for the travel vaccination and prophylactic treatment services and the EHC service.

All four resident pharmacists had level two safeguarding accreditation, and all the staff had completed the pharmacy's annual safeguarding training. The pharmacy had its own safeguarding procedures available for reference, but it did not have the equivalent for the local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe services and it reviews its staffing levels so that it can respond to changes in workload. And the team members have the skills and experience needed for their roles. Each team member has a performance review and completes relevant training, so their skills and knowledge are generally up to date.

Inspector's evidence

The staff present included the RP, a second resident pharmacist, a pre-registration pharmacist (pre-reg) a dispenser and a medicines counter assistant (MCA). The other staff, who were not present, included three other resident pharmacists, two dispensers, two staff who were in training for the combined role of dispenser and MCA, one MCA, and a pharmacy undergraduate student. The pharmacy also employed a temporary staff member who was a medical undergraduate in the period up to Christmas. All the qualified staff had worked at the pharmacy for at least one year, so the team was relatively stable.

The store management team, who managed the pharmacy, consisted of the store manager, who was also a pharmacist and several assistant managers, a few of who were dispensers. The pharmacists reported to the store manager, and the rest of pharmacy team reported to assistant managers.

The pharmacy usually had enough staff to comfortably manage the workload. The team had repeat prescription medicines ready in good time for when people needed them. The pharmacy received most of its prescriptions via the electronic prescription service, a large proportion of which came via its prescription ordering service. Many of the vaccination services were appointment based. These systems cumulatively helped to maintain service efficiency. The pharmacy had a steady flow of people presenting for advice, so the pharmacist spent a large amount of their time on the front counter. Nevertheless, they could simultaneously manage the dispensing service without too much difficulty. The pharmacists' working hours were carefully planned. Two of them usually covered the middle part of the day when most of the appointment-based vaccinations were booked. During the flu season a third pharmacist was present, which allowed the pharmacy to run two vaccination clinics throughout the day.

Staff worked well both independently and collectively. They used their initiative to get on with their assigned roles and did not need constant management or supervision. Team members assessed whether they could satisfactorily assist people who initially requested to speak to pharmacist, which in around sixty percent of cases they could. The RP said that there was potential for staff to handle many more of these requests, because in hindsight there were other occasions when they could have dealt with them instead of the pharmacist.

The dispensers worked flexibly, moving between the front counter and dispensary depending on the priorities throughout the day. The pharmacy undergraduate regularly worked as a dispenser during the weekend. And some of the MCAs were also qualified dispensers, so were available to provide dispensing support if necessary. However, they did not regularly work in the dispensary, so their appropriate skills and familiarity with the relevant procedures could be less well maintained. The other MCAs carried out much of the administrative functions of the dispensing services, which helped to

maintain them. However, there was no plan for them to also train to become dispensers, which could help the pharmacy manage busy periods more effectively.

The pharmacy had an effective strategy for covering planned and unplanned leave. Only one dispenser and one MCA, depending on their working days and hours, were allowed planned leave at any time. The pharmacy's area management team had a group of relief pharmacists available to provide cover. And the vaccination clinic appointment diary was reviewed appropriately in respect of the covering pharmacist's vaccination accreditations. This helped to avoid people booking appointments that either could not be honoured or delayed. The RP said this usually was not problematic as the pharmacist sent to provide cover typically had the necessary qualifications. And one of the resident pharmacists could still provide a temporarily scaled-down vaccination service if the other pharmacists could not. The qualified staff in the store management team were also available on the rare occasions when the pharmacy needed cover for unplanned leave.

The pharmacy provided two off-site training days for the pre-reg, who felt well supported in progressing their knowledge and skills. One of the two team members in training to become MCAs and dispensers had progressed well towards accreditation. However, the other trainee's progress had slowed slightly. This had been recently identified and the trainee had recently been given additional support via protected study-time and spent a larger proportion of their working time in the dispensary training. The early indications were positive as they now only needed minimal supervision. Team members were up-to-date with the pharmacy's mandatory e-Learning training that covered its policies, procedures and services. And staff had protected study time to complete their training. Each team member also had a recent performance appraisal.

The pharmacy had revenue targets for its non-dispensing services, which the RP said were mostly realistic and achievable. Senior management remained positive if the pharmacy achieved a large proportion of each target and understood that it had done everything that could be reasonably expected to achieve them. Although these targets generally increased in recent years, this was mainly because of new services being offered, and they were kept under review following feedback from the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s services. It has a private consultation room, so members of the public can have confidential conversations and maintain their privacy.

Inspector's evidence

The pharmacy was situated in a purpose-built unit. Its retail and dispensary fittings that were suitably maintained and professional in appearance. The retail area and counter could accommodate the number of people who usually presented at any one time. The open-plan dispensary provided enough space for the volume and nature of the pharmacy's services. The consultation room, accessible from the retail area, could accommodate two people, but its availability was not prominently advertised, so people may not always know about this facility. The level of cleanliness was appropriate for the services provided. And staff could secure the premises to prevent unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are suitably effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was open extended hours Monday to Saturday and normal Sunday trading hours. A step-free entrance with automatic doors and wide aisles lead to the pharmacy at the rear of the store. All four resident pharmacists had influenza, meningitis B, chickenpox and travel vaccination accreditation, which meant people could access these services across most of the week. And they followed appropriate written procedures, which helped to make sure the service was delivered safely.

The pharmacy effectively signposted people who NHS urgent care had referred to it when it was suspected they needed a CD or antibiotic prescription. The pharmacist also contacted other pharmacies when they did not have any medication for an urgent prescription received during the evening or weekends. However, they had experienced some difficulties contacting all the pharmacies in the locality as not all of them were on the NHS urgent care mailing list. This had been raised with the local NHS commissioning group.

The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including insulin, anti-coagulants, methotrexate and lithium. The staff had been briefed on dispensing valproate safely. The pharmacists had previously checked if the pharmacy had any people in the at-risk group for valproate, which it did not, and they were also completing a valproate audit. However, staff could not locate the MHRA valproate advice booklets and cards to give people, but they knew how to obtain them. The team regularly checked if people on anti-coagulants and methotrexate had a recent blood test, if they were experiencing side effects or interactions with each prescription received and counselled them if necessary. The pharmacists were also completing an audit of people taking methotrexate.

The team prompted people to confirm the repeat medications they required, which helped limit medication wastage and made sure people received their medication on time. It also made corresponding records of the medications requested, so it could effectively resolve queries about requests. The pharmacy had also recently introduced an online tool that people could request their medication directly with the surgery, which improved service efficiency.

The team consistently used a formal checklist to review and communicate clinical matters about people's prescriptions. It used tubs during the dispensing process, which helped to organise its workload. It marked part-used medication stock cartons, which helped make sure it gave people the right amount of medication.

The pharmacy obtained its medicines from a range of licensed pharmaceutical wholesalers and stored all of them in an organised manner. The system for complying with the Falsified Medicines Directive (FMD) had not yet been installed, and staff did not know when they would receive it.

The team suitably secured its CDs, quarantined date expired and patient returned CDs, and had

destruction kits for destroying CDs. It monitored its refrigerated medication storage temperatures. Records indicated that all the stock had been regularly date checked during 2018 and from July 2019 onwards. Staff recalled date-checking the stock between January 2019 and July 2019, but they had not made corresponding records. The pharmacy had recently reduced its stock by a significant amount and planned to reduce again it by a quarter, which should facilitate managing the medication held. The team took appropriate action when it received alerts for medicines suspected of not being fit for purpose and recorded the action that it had taken. The pharmacy disposed of obsolete medicines in waste bins kept away from medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable.

The team used an alpha-numeric system to store people's dispensed medication, which meant it could efficiently retrieve patient's medicines when needed. The staff wrote the supply deadline date on stickers that they applied to dispensed CDs, which reminded the pharmacist to check the date before supplying them. And the resident pharmacists regularly reviewed the stored dispensed CDs each week, which helped to make sure it only supplied CDs when it had a valid prescription. The pharmacists initialled each CD register supply entry, so there was an audit trail that identified who was responsible for each supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively, which it properly maintains. And it has the facilities to secure people's information.

Inspector's evidence

The team kept the dispensary sink clean, it had access to hot and cold running water and an antibacterial hand-sanitiser. The team had a range of clean measures, including separate ones for methadone. So, it had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. Staff had access to the latest version of the BNF and a recent cBNF, which meant it could refer to pharmaceutical information if needed.

The pharmacy team had facilities that protected peoples' confidentiality. It viewed people's electronic information on screens not visible from public areas and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public view.

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.