General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 30-36 Gallowtree Gate, LEICESTER, Leicestershire, LE1 1DD

Pharmacy reference: 1034053

Type of pharmacy: Community

Date of inspection: 30/11/2022

Pharmacy context

This pharmacy is situated in Leicester town centre. It has a public-facing pharmacy downstairs on the ground floor and an online business with no access to members of the public upstairs. Most of its activity is dispensing NHS prescriptions and delivering medicines to people's homes. And it offers substance misuse treatment, supplies medicines in multi-compartment compliance packs and a seasonal flu vaccination service. The pharmacy also offers an emergency hormonal contraception service, Hypertension case-finding, New Medicine Service and a prescription delivery service.

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	1.1	Good practice	The pharmacy proactively reviews its services and changes its procedures to reduce risks and improve its service.
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 proactively reviews its services and changes its procedures to reduce risks and improve its service. And it keeps the records it needs to by law, to show that medicines are supplied safely and legally. Members of the pharmacy team record and review their mistakes so that they can learn and improve from these events. The pharmacy keeps people's private information safely and its team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). The online pharmacy had some additional SOPs that reflected the service they provided. The online pharmacy had very recently reviewed and changed some processes including the triage process and introduced new SOPs. To make sure that the team members had read, understood and implemented the SOPs, their manager assessed their understanding and competence in the new SOPs before signing them off. Staff in both the online dispensary and the dispensary providing public-facing services were seen dispensing medicines safely. In the public-facing dispensary the SOPs had been read and signed by its team members. The correct responsible pharmacist (RP) notice was on display and members of the pharmacy team could describe the tasks they could or could not undertake in the absence of a pharmacist. Members of the pharmacy team knew that prescriptions for controlled drugs (CDs) not requiring secure storage such as tramadol, had a 28-day validity period. And stickers were used to mark such prescriptions to minimise the risk of inadvertently supplying these beyond their validity period.

The online pharmacy had considered the risks of the particular service that it was providing. The website set out timescales for delivery and advised people who needed acute medicines not to use the service. Some medicines such as antibiotics and creams were picked up in the triage process and the person contacted to make sure they didn't need them immediately. If they did, the prescription was returned to the NHS spine to be dispensed elsewhere. Guidance could be extended to include other medicines which people might need acutely. People could order directly with their own surgery or through the Boots website. If someone ordered directly with their surgery, there was a process to make sure that they had intended for their prescription to go to the pharmacy. Prescriptions received were checked against the order on the website and the person and their surgery were contacted if there were any discrepancies. People were contacted if there were any problems with the prescription, for example if the medicine was out of stock.

The pharmacy had systems to record dispensing incidents. Near misses (errors which were identified before the medicine was handed out to a person) and dispensing errors (errors that had been identified after people received their medicines) were routinely recorded on-line and reviewed monthly as part of a patient safety review process. A team member explained that the pharmacy did not have many dispensing incidents since the installation of a new IT system (Columbus). Most mistakes involved incorrect quantities and the team was mindful of double-checking quantities during the final accuracy check. Higher-risk medicines and some medicines with similar names such as amlodipine and amitriptyline had been highlighted and separated to minimise the chances of picking errors.

The pharmacy had current indemnity insurance. Records about CDs, RP and private prescriptions were kept in line with requirements. A random balance check of a CD showed that the quantity of stock in

the cabinet matched the recorded balance in the register. Running balances of CDs were kept and audited weekly. A separate register was used to record patient-returned CDs.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was separated from general waste and was stored and destroyed appropriately. Professional indemnity insurance was in place.

The pharmacy had procedures about protecting vulnerable people and the pharmacists had completed level 2 safeguarding training. Members of the pharmacy team involved in public-facing services were aware of the Ask for ANI (action needed immediately) initiative to help people suffering from domestic abuse access a safe space. And the information about the safe space initiative was prominently advertised in the pharmacy. Details of local agencies to escalate any safeguarding concerns were available in the pharmacy. A member of the online pharmacy team explained how they had contacted local health services for a potentially vulnerable person who had not ordered medicines for several months. A visit had been made and everything had been fine.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its current workload. Members of the pharmacy team work well together, and they can raise concerns or make suggestions to help improve the pharmacy's services. And they have access to training resources to help keep their skills and knowledge up to date.

Inspector's evidence

Although busy during the inspection the pharmacy team managed the day-to-day workload well. They worked together as a team, giving each other advice and support. Both the dispensaries had sufficient staff who were trained and competent in the tasks that they completed. The RP worked in the public facing pharmacy downstairs. There was a pharmacy manager who managed the online part of the business upstairs. Although they spoke with each other during the day they were fundamentally run as two separate businesses with each having a separate internal store number.

Staff were supported in their development. For example, a pharmacy technician had said that she wanted to be an accuracy checking technician when she joined the pharmacy had been trained and was now in that role. Staff had regular appraisals. The pharmacy team was given time where possible, during working hours to help complete their training. A whistle blowing policy was available in the pharmacy and team members felt supported to raise any concerns or make suggestions to improve the pharmacy's services. The team did not feel patient safety or the team's professional judgements were compromised by targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are safe and adequately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

Inspector's evidence

The public-facing part of the pharmacy had a spacious-sized retail area and a dispensary which was a reasonable size for the services provided. There were separate areas for the assembly and checking of medicines. There was adequate heating and lighting with hot and cold water available. A small-size basically fitted out consultation room was available for people to have a private conversation with pharmacy staff.

The online part of the pharmacy was a good size for the services that it provided. There were separate areas for the different parts of the team such as customer services, triage, and dispensing. There were separate areas for the assembly and checking of medicines. Air conditioning kept the dispensary at a reasonable temperature; hot and cold water were available. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services well to ensure people get appropriate care and support to manage their medicines safely. People with different needs can access the pharmacy's services. The pharmacy gets its medicines from licensed wholesalers, and it stores them appropriately. Members of the pharmacy team take the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The public-facing pharmacy had flat access with automatic doors which made it easy for people with a disability or with a pushchair to get into the pharmacy. Its opening hours and the services it offered were well advertised in-store. There was seating available for people waiting for services. Members of the pharmacy team used their local knowledge to signpost people to other providers where appropriate. The pharmacy offered a prescription delivery service and people signed to acknowledge receipt of their medicines.

Members of the pharmacy team used containers to minimise the risk of medicines getting mixed up. 'Owing notes' were issued to keep an audit trail when prescriptions could not be supplied in full when first dispensed. The workflow in the dispensary was sufficiently organised. The pharmacy had a significant number of people on substance misuse treatment. A hatch was used to administer and supervise the medicines and it offered good privacy to people receiving the treatment. The instalment medicines were prepared in-advance and included appropriate labelling requirements. An audit trail was kept of people attending for services and appropriate records for the supplies were made. The pharmacy had recently started offering the Hypertension case-finding service. The RP said that most people seen had blood pressure levels in the normal range and she hadn't had the opportunity yet to fit the ambulatory blood pressure monitor. The RP had completed an e-learning training. The pharmacy dispensed medicines in multi-compartment compliance packs to people who needed assistance in managing their medicines at home. The service was generally well-managed, and the compliance packs seen during the inspection included the relevant labelling details. Patient information leaflets were supplied.

Members of the pharmacy team used laminated cards when dispensing higher-risk medicines such as lithium, methotrexate, warfarin, paediatric prescriptions, and CDs, so that the pharmacist could provide additional advice to people when these were handed out. And they knew about the Pregnancy Prevention Program for people in the at-risk group who were prescribed valproate containing medicines. The pharmacy had appropriate leaflets and information to be provided when supplying these medicines to people in the at-risk group. Clear bags were used for dispensed CDs and temperature-sensitive medicines to help team members identify and query any items with people at hand-out. The pharmacy had begun delivering its flu vaccination service in September and over 1500 vaccinations had been administered to date. A needle-stick injury procedure and all the ancillary items such as gloves, swabs, hand-sanitisers, and anaphylaxis kit were available in the consultation room.

The pharmacists gave a range of advice to people using the pharmacy's services. This included advice when they had a new medicine or if their dose changed. In the online pharmacy, the pharmacist made records when she spoke to people who took medicines that required ongoing monitoring such as

warfarin or methotrexate. This meant that helpful information was available for other pharmacy staff to refer to. She was able to explain the action that she would take if they could not contact the person to get the information required.

The online pharmacy offered either a delivery service to people, or they could pick their medicines up from a local Boots store. The pharmacy used Royal Mail and were able to track a delivery if something had gone wrong. People were able to choose ‘signed for’ or a ‘through the letter box’ service. If the medicine was a CD which required a signature or if it was too big to go through a letter box it was changed to 'signed for' if the letter box service had been requested. The pharmacy had made provision for Christmas and the Royal Mail strikes.

Prescriptions were either dispensed at the pharmacy or sent to the distance selling pharmacy (DSP) owned by the same company for dispensing. About 60% of prescriptions were sent to the DSP which allowed the pharmacy to manage the workload effectively. The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label and a quad stamp on the prescription to help identify who had done each task. There was also an electronic audit system with the PMR system. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error.

Medicines were stored tidily on shelves in their original containers. The pharmacy had records of regular date-checking of medicines. A quick check of a small number of stock medicines didn’t find any that were out of date. Opened bottles of liquid medications with limited stability were marked with the date of opening to ensure they were fit for purpose when supplied to people. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacy had a process to deal with safety alerts and medicine recalls making sure the medicines it supplied were fit for purpose. Records about these and the action taken by team members were kept, providing an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And team members use the equipment in a way that protects people's privacy and dignity.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids with separate marked measures used for certain liquids. A separate triangle was used for cytotoxic medicines. The pharmacy had up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy had the necessary equipment for the flu and Covid-19 vaccination service. Hand-sanitising gel was available on the medicine's counter and in the dispensary for team members and for people visiting the pharmacy. Records showed the pharmacy's portable electronic appliances were tested annually. The portable electronic appliances looked in reasonable condition.

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.