General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 24-24A Central Avenue, West Bridgford, NOTTINGHAM, Nottinghamshire, NG2 5GR

Pharmacy reference: 1035622

Type of pharmacy: Community

Date of inspection: 05/06/2024

Pharmacy context

This community pharmacy is on the main shopping street in the town of West Bridgford in Nottinghamshire. It is open seven days a week. Its main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy offers a range of consultation service including the NHS New Medicine Service (NMS), NHS blood pressure check service and NHS Pharmacy First service. The pharmacy supplies some medicines to people residing in care homes, it also supplies a small number of medicines to people in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

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 acts effectively to identify and manage risks for the services it provides. It keeps people's confidential information secure. And overall, it keeps the records required by law in order. Pharmacy team members understand how to respond to feedback they receive from people using the pharmacy's services. And they know how to act to help safeguard vulnerable people from harm. Pharmacy team members work well within their roles. And they engage in regular patient safety reviews to help share learning and reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a comprehensive range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. The SOPs were updated across a two-year rolling rota with new SOPs introduced to support the implementation of new services. The store manager had oversight of team members training records and demonstrated these. These showed team members completed relevant learning to support them in understanding the pharmacy's SOPs. Some team members recently returning to work following planned leave or recently changing their roles had learning to complete. Pharmacy team members were observed completing tasks in the dispensary and at the medicine counter in accordance with SOPs. A team member described the activities that could not take place if the RP took absence from the pharmacy.

Dispensing tasks took place in two dispensaries: the main dispensary and the care home dispensary. There were clear lines of accountability between both teams and the responsible pharmacist (RP) assumed responsibility for all registered activities taking place. The RP was supported by an accuracy checking pharmacy technician (ACPT) working in the care home dispensary. The ACPT discussed how they applied their professional judgment when working and they were confident in referring to a pharmacist when they had a concern, including when there was a need to query information a pharmacist had clinically checked. Another pharmacist conducted consultations with people who had received new medicines on behalf of pharmacies within the company through providing New Medicine Service (NMS) consultations remotely from an office within the pharmacy.

Pharmacy team members recorded mistakes made and identified during the dispensing process, known as near misses. A team member in the main dispensary felt the team was good at recording its near misses when a regular pharmacist was working. They identified some areas of improvement in completing these records when working with relief or locum pharmacists. The team in the care home dispensary explained they recorded all near misses and recognised the importance of doing this to support them in identifying trends and actions to reduce risk. Both dispensary teams held monthly patient safety reviews. These reviews supported the teams in identifying trends in mistakes, and records showed the actions the teams were taking to reduce risk. Recent actions included a focus on quantity errors. And the need to share information with each other when team members noticed repeat requests for higher-risk pharmacy (P) medicines subject to abuse, this included the need to refer these requests to the RP. Both teams demonstrated how they used the patient medication record (PMR) safety tools to support them in scanning the barcodes of medicines to help reduce mistakes during the dispensing process. Team members highlighted medicines that would not scan on prescription forms. This prompted additional care from accuracy checkers. Both teams recorded any

mistakes identified following the supply of a medicine to a person, known as a dispensing error. The teams followed an investigation process to help determine the root cause of these mistakes and to identify actions required to reduce the risk of similar events occurring. For example, introducing an additional check during the dispensing process when dispensing controlled drugs (CDs).

The pharmacy advertised its feedback and complaints process to people using its services. It attached information to assembled bags of medicines informing people how they could provide feedback about their experience. Pharmacy team members understood how to manage feedback and provided examples of how they responded to queries and concerns. Team members engaged in mandatory learning on confidentiality and data security. The pharmacy held all personal identifiable information in staff-only areas. It segregated confidential waste and securely disposed of this. The team engaged in mandatory safeguarding learning to help protect vulnerable people. Team members discussed how they would use their knowledge and experience to recognise and raise safeguarding concerns. The pharmacy advertised its consultation room as a safe space. A team member explained how they would offer this safe space to people using code words associated with safety initiatives designed to offer a safe space to people experiencing domestic abuse.

The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records examined generally complied with legal requirements. But pharmacists did not always enter the address of the wholesaler in the CD register when entering the receipt of a CD. The pharmacy maintained running balances in the CD register and completed full balance checks of physical stock against the register balance frequently. Random physical balance checks of CDs conducted during the inspection matched with the running balances in the register. A note left by a locum pharmacist identified a discrepancy in the running balance of one CD. The store manager provided follow-up information of an investigation and the cause of this discrepancy shortly after the inspection visit. They provided assurances the discrepancy was resolved and information about learning the team was taking forward to reduce the risk of a similar event occurring. The team recorded patient-returned CDs in a separate register at the point of receipt. There were two returns registers in use, and these showed a build-up of returns waiting for secure destruction. A discussion highlighted the need to keep one complete register to support the safe and timely management of patient-returned CDs. The pharmacy entered the private prescriptions it dispensed in an electronic private prescription register. Most records conformed to legal requirements. But occasional records showed team members did not always accurately record the details of the prescriber or the date of the prescription when making these records.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team of people with the appropriate skills and knowledge to delivery its services. Pharmacy team members work together well. They engage in structured reviews to support their learning and development. And they contribute to regular conversations to share learning improve patient safety. They understand how to provide feedback at work. And they have access to information to support them in raising a professional concern if needed.

Inspector's evidence

The RP was working with a trainee pharmacy technician and a pharmacy student in the main dispensary during the inspection. The pharmacy's ACPT was working with a trainee pharmacy technician and a qualified dispenser in the care home dispensary. The store manager was a qualified dispenser and was observed supporting the team in the main dispensary throughout the inspection process. Team members explained that both the manager and the assistant manager worked regularly to support them in managing workload. The pharmacy also employed two trainee healthcare assistants and three other qualified dispensers, one of which was the pharmacy's assistant manager. Other employees had store-based roles and were not involved in the provision of pharmacy services. The pharmacy had a current part-time vacancy for a dispenser. The pharmacy student was working additional hours to support the team during the summer period. The pharmacy was up to date with its workload on the day of inspection. The manager stated that support was available from the company's relief team of pharmacists and dispensers during periods of staff absence. Team members from both dispensaries took the opportunity to discuss rising pressures across community pharmacies. They provided examples of some of the challenges they faced when providing pharmacy services and how they worked together to overcome these.

Pharmacy team members engaged in structured performance reviews to support their learning and development needs. They had regular training time at work and completed continual learning for their role. A team member enrolled on an accredited learning course described receiving protected learning time and regular one-to-one support from a pharmacist. The ACPT had recently attended a company learning event aimed at exploring the changing roles of pharmacy technicians and they spoke positively about this event. The pharmacy had some targets aligned with its services. For example, the number of blood pressure checks it conducted. The RP discussed how they applied their professional judgement when providing consultation services. The pharmacist who provided remote NMS consultations felt the service supported pharmacists working in this pharmacy and other pharmacies to focus on the delivery of other services.

Pharmacy team members engaged in regular conversations about patient safety, including structured team briefings as part of the monthly patient safety review held in both dispensaries. The most recent patient safety review for each dispensary was displayed to remind team members of shared learning and the key action points agreed. Team members were also encouraged to read newsletters published by the superintendent pharmacist's team designed to share learning across the company. And they received regular updates following area conference calls attended by managers. Team members in the care home dispensary discussed reaching out to the company's pharmacy support team for assistance following some recent actions about the management of owed medicines. The pharmacy had a whistle

blowing policy and team members were aware of how they could provide feedback or raise a concern at work. A team member explained the manager had recently taken an opportunity to remind all team members of the availability of a confidential helpline they could access.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. It offers a professional image for delivering healthcare services. People using the pharmacy are able to speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance, it consisted of a large retail space stocking a large variety of toiletries and personal care items. Healthcare items and General Sale List medicines were held close to the medicine counter. The pharmacy stored P medicines behind the medicine counter. The main dispensary led from the side of the medicine counter, access behind the counter and to the dispensary was deterred through the placement of tape barriers. The pharmacy's consultation room was an adequate size, and it was clean and professional in appearance. A door leading from the back of the retail area was accessible to store employees only. This provided access to a small warehouse, an office, staff toilet facilities and a good-sized care home dispensary. Pharmacy-only areas within the warehouse were accessible only to members of the pharmacy team. Another door to the side of the retail area led to the upstairs of the premises. This provided access to staff break facilities and amenities. An office in this room was used by a pharmacist providing remote NHS NMS consultations.

Pharmacy team members reported maintenance issues to a designated helpdesk. There were two outstanding maintenance issues, the team had reported both. One of the issues had seen a temporary fix applied pending further works taking place. The pharmacy was clean and organised, a store cleaner was employed to support with cleaning tasks. Lighting was bright and air conditioning maintained an appropriate temperature for delivering pharmacy services. Pharmacy team members had access to antibacterial liquid soap and paper towels were available close to designated hand washing sinks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are easily accessible to people and it promotes its services well. It obtains its medicines from reputable sources. And overall, it stores them safely and securely. Pharmacy team members take time to engage people in conversations about their health and the medicines they take. And they provide relevant information to people to help them take their medicines safely.

Inspector's evidence

People accessed the pharmacy through automatic doors at street level. The pharmacy clearly advertised its opening times and details of its services for people to see. Team members felt the promotion of services such as the NHS blood pressure check service had led to an increase in people accessing the service. They understood the importance of signposting people to other healthcare providers or pharmacies when needed.

The pharmacist providing the remote NMS serviced discussed the importance of giving people advice on actions to take if their condition changed or if they had further concerns about their health. They felt able to have quality conversations with people to support them in understanding their new medicines and to discuss the importance of adopting healthy lifestyle practices. And they provided examples of positive interventions and support provided through the service. They could access and add to people's PMR to support them in delivering the service and make effective records of the consultations taking place. There was a clear process for communicating with people's own local pharmacy. The RP in the local pharmacy retained responsibility for communicating with people's GPs due to the local relationship they had with them. Pharmacists had supportive information readily available to them to support them in providing consultation services safely. This information included service specifications, patient group directions and protocols for the services provided, such as clinical pathways for the Pharmacy First service. Observations during the inspection showed team members being attentive to people's needs and providing helpful information to support them in accessing healthcare services.

The team used effective tools to support the supply of higher-risk medicines to people. These tools included identifying higher-risk medicines through the use of bright laminated cards throughout the dispensing process. The cards remained with prescription forms until the point of hand-out or delivery. And the team followed prompts on the back of the cards to inform counselling. A team member confidently explained the requirements of the valproate Pregnancy Prevention Programme, including the counselling required and the need to supply valproate in the manufacturers original packaging. Another team member discussed the checks they made before supplying warfarin to people. The team made records of the checks and advice given when supplying higher-risk medicines on people's PMR to support continual care.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to provide an audit trail of their role within the dispensing process. They completed separate audit trails on prescription forms to identify which team member had completed specific tasks during the dispensing process. Team members generated a pharmacist information form (PIF) for each prescription dispensed. The PIF highlighted key information to support the clinical check of prescriptions and the accuracy check of medicines. They used tubs and trays when dispensing

medicines. This separated people's prescriptions from others to avoid items being mixed up. Both dispensary teams were observed supplying patient information leaflets with the medicines they dispensed.

The pharmacy retained prescriptions for owed medicines, and its team members dispensed from the prescription when later supplying the owed medicine. The pharmacy maintained an electronic audit trail of the medicines it sent through its delivery service. The RP was observed completing a thorough handover check with a company-employed delivery driver prior to medicines leaving the main dispensary for delivery to people. The pharmacy sent some of its workload to the company's offsite hub pharmacy. It had effective processes and audit trails for the transfer of prescription data to the hub pharmacy and for processing the sealed bags of assembled medicines it received back from the hub. Pharmacists clinically checked prescriptions and checked the accuracy of the data sent to the hub pharmacy. Team members used barcode technology to track prescriptions. If part of the prescription required the team to dispense medicines locally, the team assembled and checked these medicines following receipt of assembled medicines from the hub pharmacy. This helped to ensure it stored both bags of medicines together and mitigated the risk of people only being supplied with part of their prescription.

The team working in the care home dispensary demonstrated safe working practices when dispensing medicines. Its processes ensured a pharmacist carried out the clinical check of the prescription with supportive information available to them ahead of assembling and checking tasks taking place. And ensured medicines were supplied with an accompanying medication administration record (MAR). One team member each day took responsibility for managing acute prescriptions, known as interims. This supported the team in dispensing interim items effectively alongside its managed workload. The team highlighted any urgent tasks or information to the RP via a red tray and it kept a record of the checks of this tray. It recorded communication with prescribers and care homes in a duplicate pad, the top copy of this duplicate record accompanied the prescription throughout the dispensing process to ensure all team members had access to the information. The team followed the pharmacy's SOPs when reporting queries to the care homes and notifying them of missing items or owed medicines. And it appropriately sealed and securely stored containers containing bags of assembled medicines waiting for delivery to the homes. The team was also responsible for the supply of medicines in multi-compartment compliance packs. People receiving their medicines in this way had engaged in an assessment to help ensure this was the most effective way for the pharmacy to supply their medicines. The pharmacy kept records to support them in supplying medicines in compliance packs safely. There were no assembled compliance packs waiting for collection or delivery to people on the day of inspection. A team member discussed how the team provided the service and used audit trails to demonstrate who had undertaken tasks during the dispensing process.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner. And it recorded regular checks of the medicines it held to ensure they remained safe to supply. A random check of dispensary stock found no out-of-date medicines. The team generally marked liquid medicines with details of their opening dates to ensure they remained fit to supply. One liquid medicine with a shortened shelf life of six-months after opening was not marked, this was removed from stock and brought to the direct attention of the RP. The pharmacy stored CDs in secure cabinets and the storage of medicines within each cabinet was organised. Patient-returned CDs waiting for secure dispsoal were appropriately labelled and segregated from stock medicines. The pharmacy had two medical fridges and it held medicines inside each fridge in an orderly manner. It maintained records of the operational temperature of each fridge, these records had recently supported the team in identifying a concern and taking timely action to replace a fridge. The pharmacy had medicine waste receptacles, sharps bins and CD denaturing kits available to support the safe

disposal of medicine waste. It received medicine alerts electronically and it shared these with both dispensaries before making a record of any action required in response to the alert. Records showed the team was up to date with the actions required in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment and facilities it needs to provide its services. And its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

The team had access to a wide range of digital reference resources via an online subscription service. The NMS pharmacist discussed the benefits of having these reference resources to hand when holding telephone consultations with people. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines safely and in a way which meant details on bag labels and prescription forms could not be read from the public area.

Pharmacy team members had access to appropriate telephone equipment to support them in maintaining people's confidentiality when speaking to them on the telephone. The NMS pharmacist had access to a handsfree phone with an earpiece and a desk that allowed them to stand whilst working. The pharmacy team used a range of equipment to support it in delivering the pharmacy's services. This included appropriate equipment for counting and measuring medicines. It clearly marked and stored equipment for counting and measuring higher-risk medicines separately. Equipment seen was from reputable manufacturers and pharmacists cleaned and checked it prior to providing consultation services. The pharmacy's electrical equipment was annotated to show it was regularly checked to ensure it was in safe working order.

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.