General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 16 Eaton Place, Bingham, NOTTINGHAM, Nottinghamshire, NG13 8BD

Pharmacy reference: 1035638

Type of pharmacy: Community

Date of inspection: 09/01/2023

Pharmacy context

This community pharmacy is in a pedestrianised area in the centre of Bingham, a small town in Nottinghamshire. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy offers a seasonal flu vaccination service to people. It supplies some medicines 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	3.2	Good practice	Pharmacy team members actively promote access to the pharmacy's private consultation room. The room is fitted with effective soundproofing to protect people's privacy.
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 has effective governance processes that identify and manage the risks associated with its services. It keeps people's private information secure. And it generally keeps the records it must by law. The pharmacy advertises how people can provide feedback about its services. Its team members regularly share learning following mistakes made during the dispensing process to help reduce the risk of similar mistakes occurring. And they have the knowledge to recognise and raise concerns to support vulnerable people.

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 company was in the process of making its SOPs available to team members via an electronic portal. An up-to-date contents section within the SOP folder informed team members whether the most recent version was available as a hard copy or electronically. A sample of training records confirmed team members completed regular learning related to the SOPs. These involved completing e-learning associated with each SOP and completing an assessment to test their understanding of the SOP. Pharmacy team members had a good understanding of their roles and responsibilities, and they were observed working in accordance with both dispensing and sales of medicines SOPs.

Pharmacy team members acted with care by acknowledging safety prompts provided by the computer system during the dispensing process and they were aware of common patterns in mistakes caused by human errors. For example, quantity errors when splitting original packs of medicines. Pharmacy team members were encouraged to reflect on mistakes made and identified during the dispensing process, known as near misses. They took the opportunity to record most of these mistakes and frequently discussed the mistakes as a team. The responsible pharmacist (RP) explained clearly how they would respond to a situation involving a mistake that was identified following the supply of a medicine to a person, known as a dispensing error. This explanation included seeking support from the team to report the mistake. A team member held the role of patient safety lead, and part of this role included reviewing safety events each month. There were some minor gaps in these formal reviews. But a sample of completed reviews found that team members were good at identifying improvements to support a safe and effective working environment. These improvements ranged from applying additional care and checks during the dispensing process to ensuring pharmacy records were maintained accurately. For example, the team had acted to ensure consistent recording of fridge temperatures by placing reminders in the pharmacist duty folder. And they had reviewed this action at its next patient safety review to ensure it had worked effectively.

The pharmacy advertised how people could provide feedback and raise a concern. Its team members were observed being attentive to people's needs and acknowledged people waiting at the medicine and pharmacy counter if they weren't able to serve them immediately. Pharmacy team members recognised how they would manage feedback and understood how to escalate a concern when required. The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated bags. And these bags were sealed and sent for secure disposal regularly. All team members engaged in mandatory learning relating to confidentiality and data

security. They also engaged in safeguarding learning to help protect vulnerable people. The RP on duty, a locum pharmacist, explained how locums were asked to provide evidence of this learning ahead of commencing shifts for the company. Contact information for local safeguarding agencies was readily available to team members. The pharmacy advertised its consultation room as a 'safe space' and its team members were aware of how to respond to safeguard a person through the 'Ask for ANI' safety initiative, designed to protect people suffering domestic abuse.

The pharmacy had up-to-date indemnity insurance. The RP notice displayed was updated shortly after the inspection process began to reflect the correct registration number of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy generally kept the records required by law in good order. There were some minor improvements identified in the controlled drug (CD) register as the pharmacy team did not always record the address of the wholesaler when entering the receipt of a CD in the register. The pharmacy maintained running balances in the register. And the team completed weekly full balance checks of physical stock against the register. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members work together well, and they are keen to implement their ideas to support a safe and effective working environment. They understand how to raise concerns at work. And they engage in learning to support them in their roles.

Inspector's evidence

The store manager was a qualified dispenser, and they led a team of three dispensers, a pharmacy technician, and three other team members. Two of these team members were currently enrolled on accredited learning programmes to support them in their roles. And the third team member worked as a customer advisor and did not have a direct role in providing pharmacy services or supporting the sale of Pharmacy (P) medicines. Company employed delivery drivers provided the medicine delivery service. The manager had joined the team in Autumn 2022, prior to this it had been without a manager or regular pharmacist for some time. Locum pharmacists and members of the area relief team provided pharmacist cover. The locum pharmacist on duty was familiar with the pharmacy and was observed working well together with team members when providing pharmacy services. The pharmacy team was slightly behind with managed workload due to some recent absences and heightened winter pressures. But team members organised the backlog in a structured way, and prioritised work associated with acute prescriptions and people presenting to collect their medicines.

Pharmacy team members could take some time at work to support ongoing learning, but they completed e-learning on a computer in the dispensary rather than in a protected environment. And some team members chose to complete learning in their own time at home. Pharmacy team members were supported by an ongoing appraisal process, they had yet to engage in a one-to-one with the new manager. The pharmacy had a whistleblowing policy and pharmacy team members understood how to raise concerns and provide feedback at work. They had requested some additional support during a period of workload pressure in 2022, and appropriate support had been made available. The RP explained that specific targets had not been discussed with them ahead of booking their shifts at the pharmacy. They discussed the company’s expectations related to engagement in services and confirmed they felt able to apply their professional judgment when providing services.

Pharmacy team members engaged in continual discussions related to patient safety and risk management. Team members worked together well and were highly focussed on creating a safe and efficient work environment. They had introduced a number of measures to reduce risk when providing pharmacy services. For example, they attached brightly coloured notes to the CD register when dispensing CDs. This prompted additional checks to ensure entries were being made within the right section of the register.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. Its team members actively promote the availability of the consultation room. And this room is fitted with effective soundproofing to ensure people's privacy is maintained.

Inspector's evidence

The pharmacy was secure and appropriately maintained. Pharmacy team members understood how to report maintenance concerns. The pharmacy was clean and generally organised. A workbench in the dispensary was lined with tubs containing prescriptions yet to be dispensed. But team members had plenty of space for completing labelling, assembly and checking tasks at other workstations towards the front of the dispensary. Lighting was adequate throughout the premises and air conditioning supported the pharmacy in maintaining an ambient room temperature. Pharmacy team members had access to sinks equipped with antibacterial hand wash, sanitiser gel and paper towels.

The registered pharmacy was part of a larger store. The public area was fitted with wide-spaced aisles and there was a separate queuing system for the pharmacy counter and medicine counter. Team members reported that some activity relating to tasks associated with the dispensing of multi-compartment compliance packs had previously taken place on the first-floor level of the premises. The team had relocated this activity to the dispensary due to a query over the registered footprint of the pharmacy. The first-floor level of the premises provided staff facilities as well as storage space for retail stock and dispensary sundries. A lift ensured the first-floor level was fully accessible to all staff. The pharmacy's consultation room was clearly advertised, and team members promoted access to the room when people asked to speak to the pharmacist. The room had specialist acoustic soundproofing panels fitted on its walls to help ensure conversations taking place inside remained confidential. It was clean and professional in appearance and was used throughout the inspection to support delivery of the seasonal flu vaccination service. A service hatch lead from a quiet area of the store into the dispensary, this provided a semi-private area for people to speak with a team member when accessing pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. The pharmacy manages its services well. Its permanent team members follow its procedures with care. But there are occasions when some pharmacists do not complete all the written records as they should. This could increase workload pressure and make it more difficult for the team to respond to any queries that arise.

Inspector's evidence

People accessed the pharmacy through an automatic door at street level. The pharmacy clearly advertised its opening times and details of its services for people to see. It provided seating for people wishing to wait for their medicine or for a service. Pharmacy team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine. Information to support the delivery of pharmacy services was readily available. For example, pharmacists providing the flu vaccination service had up-to-date and supportive documentation and a legally valid patient group direction (PGD) to hand. And the team kept a folder of current serious shortage protocols (SSPs) readily accessible. A pharmacy technician had completed vaccination training and had supported the delivery of the private flu vaccination service by administering flu vaccinations prescribed to individual people. The pharmacy had an online booking system for its services. And the manager reflected on how this helped to manage workload.

Pharmacy team members worked well together to support the delivery of services such as The NHS New Medicine Service and the NHS Discharge Medicines Service. They made records available for pharmacists daily to support follow-up consultations and actions required to complete these services. The pharmacy was busy throughout the inspection, with many requests for advice made both at the medicine and prescription counter. Pharmacy team members were seen taking the time to speak to people about their health and wellbeing and referred people to speak to a pharmacist when required. Team members were observed managing requests for P medicines with care. They were aware of how to manage requests for higher-risk P medicines, subject to abuse, misuse and overuse.

A pharmacy team member demonstrated how the patient medication record (PMR) system identified higher-risk medicines, or medicines prescribed for a child. Pharmacy team members engaged fully in safety steps during the dispensing process, such as the proper placement of dispensing labels on packaging. The pharmacy was currently engaging in a valproate safety audit to ensure it was following the requirements of the valproate Pregnancy Prevention Programme (PPP). And its team members had completed learning associated with these requirements.

Pharmacy team members used bright laminated cards when dispensing some higher-risk medicines. They kept the cards with the medicine and prescription during the initial dispensing process. But some locum pharmacists did not work in accordance with procedures for managing these higher-risk medicines as they removed the laminated card during the final accuracy check of the prescription. The laminates were designed to stay with prescription forms until the hand-out of a medicine to prompt counselling and safety checks. Pharmacy team members had recognised that this breach in procedure meant that important safety conversations may be missed. And in response they had acted to remind pharmacists of the importance of the laminated cards in the dispensing process. The team could

demonstrate how they recorded the safety conversations that did take place on people's medication records. For example, INR test results.

The pharmacy kept each person's prescription separate throughout the dispensing process by using tubs. And there was a clear system to manage owed medicines. The pharmacy maintained an electronic audit trail of the medicines it delivered. The team used 'pharmacist information form' (PIF) throughout the dispensing process. PIFs contained key information about the prescription such as dose changes and new medicines. And pharmacy team members could add more information to the PIF to bring information to the attention of pharmacists. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed an audit trail on prescription forms to identify the person completing the labelling stage, the picking and assembly stage and the hand-out of medicines. But pharmacists did not always complete the sections of the audit grid associated with the clinical check of the prescription and the final accuracy check.

The pharmacy sent some of its workload to the company's offsite hub pharmacy. A team member demonstrated how the team managed prescriptions when sending information to the hub pharmacy. The process included ensuring data submitted to the hub was accurate. And the team followed strict processes when dispensing part of the prescription locally and sending part to the hub. Team members used barcode technology to track prescriptions, and to match locally dispensed items with those coming from the hub. This mitigated the risk of people only being supplied with part of their prescription. The pharmacy used a progress log to record tasks associated with the supply of medicines in multi-compartment compliance packs. But pharmacists did not always engage in completing this record to support the team in monitoring its progress. Pharmacy team members used individual patient record sheets to record people's medication regimens. And they clearly recorded changes to people's medication regimens on these records. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of the medicines inside the compliance packs. The pharmacy routinely supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in their original packaging in an orderly manner. The pharmacy stored CDs in secure cabinets and storage of medicines within each cabinet was organised. It had specific areas within a cabinet for holding assembled medicines awaiting checking, checked medicines awaiting supply, out-of-date medicines, and patient-returned medicines. The pharmacy had two medical fridges and it held medicines inside each fridge in an orderly manner. The pharmacy checked its fridge temperatures and recorded these daily. The records showed both fridges were operating within the accepted temperature range of two and eight degrees Celsius. The team recorded activities associated with date checking. And it highlighted short-dated medicines with stickers. A random check of dispensary stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. It received medicine alerts electronically through email and the company intranet. Both the dispensary team and the manager monitored and actioned these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the required equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

The pharmacy team had access to up-to-date written and electronic reference resources. Team members could also access information resources via the intranet, internet, and a designated telephone support line. 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 details on bag labels and prescription forms could not be read from the public area. Pharmacy team members used cordless telephone handsets when speaking to people over the telephone. And they moved out of earshot of the public area when the phone call required privacy.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. This included crown-stamped measuring cylinders for measuring liquid medicines and equipment for counting capsules and tablets. There was separate equipment available for counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Pharmacy professionals providing the flu vaccination service had access to appropriate equipment to support them in providing this service. The equipment included immediate access to medicines and equipment used to treat an anaphylactic reaction. The pharmacy maintained its equipment to help ensure it remained safe to use and fit for purpose. For example, electrical equipment was subject to regular portable appliance testing.

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.