General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 11-19 Lower Parliament Street, Victoria Centre, NOTTINGHAM, Nottinghamshire, NG1 3QS

Pharmacy reference: 1035748

Type of pharmacy: Community

Date of inspection: 06/03/2024

Pharmacy context

This busy community pharmacy is part of a large store located in a busy city-centre shopping centre in Nottingham and it is open seven days a week. It offers a wide range of services including dispensing NHS prescriptions, providing advice and medicines over the counter, the NHS Pharmacy first service, vaccination and travel health services, and medication deliveries to some people. It also participates in the 'Our future health' research programme.

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 actively encourages its team members to learn from mistakes to make its services safer.
2. Staff	Standards met	2.1	Good practice	The pharmacy has good staffing contingency arrangements to be able to cope with changing demands well.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy's team members have the right training and skills to recognise and deal with emergency situations, making sure people get the care they need quickly.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy makes sure its team members work safely by providing them with clear written procedures, suitable training, and regular updates. And by encouraging them to record and review their mistakes regularly, so they can learn and reduce risks. Team members understand what they can and cannot do when there is no pharmacist present. And they know what to do to protect vulnerable people. The pharmacy keeps the records it needs to by law. And it generally protects people's private information well.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) to make sure its services were provided in a safe way. The SOPs were reviewed regularly and there was management oversight to ensure all members of the team had read current SOPs relevant to their roles. Prior to the introduction of the new Pharmacy First service, the potential risks and impact on other activities had been considered so the new service could be delivered safely. This included looking at resources and making sure there was sufficient cover in place at the right times.

To be able to identify who undertook each stage of the dispensing process, prescription labels were initialled at the dispensing and checking stages. And there was also an additional audit trail showing who had completed data entry, the clinical check or who had handed out the dispensed medicines. This provided an assurance that all the essential steps had been taken and meant mistakes could be investigated more easily. Relevant information flagged on people's medication records was highlighted to pharmacists so it could be considered when prescriptions were checked. There were also warning cards attached to prescriptions for higher-risk medicines so people could be given additional advice when collecting their medicines.

The team members were encouraged to record mistakes that were pointed out to them and corrected during the dispensing process, known as near misses. These mistakes were then reviewed each month to identify any patterns or trends and learnings were shared with the team through a monthly patient safety review process. The team was currently trying to increase the frequency with which these events were recorded to make best use of the learning potential. Dispensing mistakes which reached patients (known as errors) were also recorded. These were subject to an in-depth review to understand what had gone wrong and any learning points for the team. And details of the outcomes and improvement points also shared with the team. An action point from a review had been to raise awareness of certain medicines with similar names to prevent selection errors. The team members commented that dispensing mistakes involving picking errors had reduced significantly since the introduction of scanning equipment which checked that the correct item had been selected. Near misses against electronic NHS prescriptions were now largely down to quantity errors.

When asked, team members could confidently explain what they could and couldn't do in the absence of a responsible pharmacist (RP). They could describe the types of questions to ask when selling medicines and knew which ingredients needed greater care including codeine and pseudoephedrine.

There was a company complaints procedure which team members were aware of. Information about how people could provide feedback about the service they had received was included on every till

receipt. There were appropriate insurance arrangements in place for the services provided.

The RP notice correctly showed who the pharmacist in charge was and it was displayed clearly. The RP record was available and was complete. Records about controlled drugs (CDs) were largely complete though there was a small number of page headers that had not been filled in. Running balances were checked regularly. One discrepancy had been found during the most recent check and the inspector received an update after the visit to confirm this had been rectified. Other spot checks of the running balances agreed with the physical stock on hand. Private prescription records were made electronically and were largely complete though the prescriber was not always recorded accurately. The store manager provided an assurance that the team would be made aware of this.

The pharmacy protected sensitive information in several ways. Confidential waste was separated and disposed of securely. There were procedures and regular, mandatory training about information governance for team members to complete. Patient medication records were password protected. Members of staff had their own NHS smartcards to access summary care records and electronic prescriptions but there was some evidence that use of these was shared occasionally. The store manager explained this was not the agreed policy and would follow-up with the team members accordingly. There was no patient-identifiable information on view to the public.

There were procedures and training to help make sure the pharmacy took appropriate action to protect vulnerable people. Staff, including the pharmacists, had completed safeguarding training relevant to their roles. There were suitable processes to escalate concerns about more vulnerable people, including people receiving substance misuse treatment who may not have collected their medication as expected.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the right skills and training to provide the pharmacy's services safely. And there are enough team members to manage the pharmacy's workload and cope with unexpected changes. Team members are well-supported in ongoing learning and development, and they have some set-aside time at work to do training.

Inspector's evidence

There were three pharmacists on duty throughout the inspection, providing cover in the dispensary and delivering services in the consultation rooms. The wider team comprised a qualified pharmacy technician, a trainee pharmacy technician, a foundation pharmacist, five pharmacy advisors, two healthcare specialist advisors and four healthcare advisors, and three pharmacy students. There was also a regular pharmacist providing cover at the weekends. The store manager and assistant store manager who had line manager responsibility for the pharmacy team could offer dispensing support to the pharmacy team and the store manager worked in the pharmacy throughout most of the visit. Though very busy and having to deal with an emergency, the team coped with the workload and managed the queues of people waiting to be served effectively. The store manager explained the recruitment plan for the store took into account the need to be able to provide skilled cover in the pharmacy and have adequate contingencies for unexpected absences or uplift in workload.

Team members were observed working closely together, referring queries to the pharmacists or more experienced colleagues where needed. They were provided with online training materials from their head office. Some of the training modules were considered mandatory to complete to ensure team members kept their knowledge current; progress against these was tracked. And the team members could have time at work to complete training. Some in-person training about off-site dispensing took place during the inspection. Team members had also completed training about the NHS Pharmacy First service though the training record sheet had not been completed by all the pharmacists; this was remedied soon after the inspection.

Team members had reviews with their manager, and these looked at how the member of staff was doing, opportunities to develop their skills, and if they needed any additional support with training. Information was shared amongst the team in a variety of ways including through team briefing materials. Team members said they could share suggestions about how to improve the way the pharmacy worked. And the team members asked said they could discuss concerns with the pharmacists, store manager or area manager. There was also a whistle blowing policy, details of which were advertised to the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are suitable for the services the pharmacy provides. The pharmacy team makes sure the premises are kept clean and well-organised to help make its services safer. And the pharmacy is kept secure.

Inspector's evidence

The pharmacy was on the first floor of the store but there were lifts and escalators available to help people who may have difficulty climbing stairs. There was some seating for people waiting for services, close to the pharmacy counter. The two, large, well-screened consultation rooms were set at a little distance from the pharmacy counter, reducing congestion around that area. These were in use throughout the visit.

Access to the dispensary was restricted and activities conducted in the dispensary were screened to reduce the risks of distraction when dispensing and to protect people’s information. Dispensary benches and kiosks were largely clear of clutter. Prescription medicines were kept out of the reach of the public. Pharmacy only medicines were monitored closely by members of staff positioned at till points just in front of the open shelf displays. There were screens that could be brought down to prevent access to these medicines if there was no RP present.

All areas of the premises were clean. Staff had access to hygiene facilities including separate hand-washing arrangements. The sink in the dispensary had hot and cold running water. The premises could be secured to prevent unauthorised access. The ambient temperature and lighting during the inspection were suitable for the activities undertaken.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. And it plans the introduction of new services appropriately. The pharmacy's team members have the right training and skills to recognise and deal with emergency situations, making sure people get the care they need quickly. The pharmacy gets its stock from reputable sources and stores it safely. It has good systems in place to make sure the medicines it supplies are fit for purpose.

Inspector's evidence

There was in-store ramped access and an escalator to the first floor of the store where the pharmacy was situated. There was also onsite parking and lift access to all floors in the shopping centre where the store was located. Aisles in the store were wide and could accommodate people with prams or wheelchairs. Staffing rotas were planned so additional services could be available across the opening hours of the pharmacy. Information about the services the pharmacy offered currently were advertised by way of leaflets and posters displayed in the pharmacy. The pharmacy participated in the 'Our Future Health' project which included taking blood samples and giving people advice about their health risks. The team members involved in this service had received dedicated training to provide this safely and the service was monitored by the commissioners.

The pharmacy team members had started providing the NHS Pharmacy First service. There was evidence of the team using an appointment system and booking people in for consultations to manage workload and waiting times appropriately. The RP explained that having three pharmacists available during the week helped make sure people could access the new service with reasonable promptness. The store manager explained there were already effective communication networks with local surgeries, and this had helped with appropriate referrals to the new service. These good working relationships had also helped when dealing with medicines shortages and seeking alternatives for people to ensure continuity of treatment.

A prescription delivery service was offered to assist some people to access their medicines. Prescription deliveries were recorded so that there was evidence to show medicines had reached the right person. People who needed their medicines in multi-compartment compliance packs were signposted to a sister branch or the pharmacy would liaise with the other branch on the person's behalf.

When asked, team members could clearly explain the information that needed to be provided about pregnancy prevention when supplying sodium valproate. And they knew how to attach dispensing labels to the manufacturer's packs so as not to obscure important information. They also knew about the recent changes that meant valproate-containing medicines were to be supplied in their original packs. Alert cards (laminates) were attached to prescriptions for valproate-containing medicines and other higher-risk medicines including CDs so appropriate counselling and advice could be given to people when they collected their medicines. The team members knew that prescriptions for CDs were only valid for 28 days and said that prescriptions for all CDs in schedule 2, 3 and 4 would be highlighted. The storage locations of some medicines including quetiapine, cytotoxic medicines, and oral anti-diabetic medicines were highlighted and were well separated from other medicines to reduce the risk of picking errors.

The pharmacy got its medicines from licensed wholesalers and unlicensed ‘specials’ were obtained from specials manufacturers. No extemporaneous dispensing was carried out. The pharmacy routinely experienced several stock shortages which were outside of its control. Examples given were certain hormone replacement therapy medicines and medicines to treat attention deficit hyperactivity disorder.

Medicine stock for dispensing was stored in an orderly fashion in the dispensary. Pharmacy-only medicines were stored on shelves beyond the pharmacy counter but access to these was closely monitored. Staff mentioned that people rarely self-selected these, preferring to ask for assistance from the specialist healthcare advisors who were always present at till points nearby. There were shutters brought down in front of pharmacy only medicines if there was no RP present.

The pharmacy checked the expiry dates of its stock regularly and kept a record about these checks. Short-dated items were identified to alert staff and reduce the risk of supplying when no longer in date. And there was a process to remove these from dispensing stock at a suitable time. Dates of opening were applied to liquid medicines so team members could assess if the medicines were still suitable to supply. When a sample of medicines was checked at random, there were no date-expired medicines found. Medicines were kept in appropriately labelled containers. Out-of-date medicines and patient-returned medicines were transferred to designated bins. These were stored away from other medicine stock and were disposed of through licensed waste contractors. There were processes followed to denature CDs before disposal. Appropriate arrangements were in place for storing CDs and access to the CD cabinets was well-controlled.

There was ample storage capacity for medicines requiring cold storage. Temperature ranges for the pharmacy fridges were checked regularly to make sure they remained suitable for storing temperature-sensitive medicines. The records seen were within the appropriate range of between 2 and 8 degrees Celsius.

The pharmacy was informed about drug recalls and safety alerts through company communications and there was a process in place to make sure the pharmacy responded to these promptly. The team was aware of a recent recall affecting Nutramigen baby formula and explained how people had been contacted to check if they still had any of the product; stock at the pharmacy was quarantined and returned to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. Its equipment is readily accessible to team members who may need to use it in an emergency. And it has processes to make sure its equipment is safe and effective to use.

Inspector's evidence

The pharmacy had measuring and counting equipment of a suitable standard to use when dispensing and providing other services. The medicine measures seen were clean and some were marked for specific use to prevent cross-contamination. There was suitable equipment for disposing of sharps waste and clinical waste arising from vaccination services and 'Our Future Health' and this was stored safely. There was also ready access to adrenaline to assist in treating suspected anaphylactic reactions promptly. The pharmacy had a range of up-to-date reference sources available for providing advice and clinical checks. All electrical equipment appeared to be in good working order and was tested regularly. Patient medication records were stored electronically and access to these was password protected. Screens containing sensitive information were not visible to the public. The staff had access to cordless phones and could move to quiet areas of the pharmacy to make phone calls out of earshot of waiting customers.

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.