General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 3A, Kingston Retail Park, Kingston Street, HULL, North Humberside, HU1 2TX

Pharmacy reference: 1089118

Type of pharmacy: Community

Date of inspection: 12/03/2020

Pharmacy context

The pharmacy is in a large Boots store close to Hull City Centre. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And the supervised methadone consumption service.

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 team members respond competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar errors happening again.
2. Staff	Standards met	2.5	Good practice	The pharmacy encourages the team members to pro-actively review the delivery of services to identify areas for improvement. The team members introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. The pharmacy team members respond competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar errors happening again. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy has arrangements to protect people's private information. And it keeps the records it needs to by law. People using the pharmacy can raise concerns and provide feedback.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Most team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. The trainee dispenser who was in post since January 2020 was in the process of reading the SOPs and signing the SOPs signature sheets. The team members had a clear understanding of their role and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. And team members usually recorded what caused the error and the actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents electronically. These were errors identified after the person had received their medicines. The team had investigated the cause of an error when a person received four weeks compliance packs when only one pack should have been supplied. The team found that the information about the frequency of the supply was not clear. So, this information had been missed by the team member handing over the packs. To prevent this error happening again the team members were reminded to write clear instructions. And the team created a dedicated drawer to store completed packs that were supplied weekly.

The pharmacy undertook a monthly patient safety review. A recent review reminded the team to ensure dose directions were fully printed on to the dispensing label. This review asked the team to double check the quantities of medication dispensed as this was a recurring error. The report also stated that the team was asked to prioritise dispensing to help with workload. The pharmacy displayed laminate cards next to the computer terminals listing medicines that looked alike and sounded alike (LASA) for the team to refer to. The list of LASA medicines included pregabalin and gabapentin. The team noticed a decrease with picking errors after an upgrade to the computers provided a facility for team members to scan the bar code on the dispensed product to see if it matched the prescription. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. The team had received training on the General Data Protection Regulations (GDPR). The pharmacy had a leaflet informing people about the confidential data it kept. And it displayed a notice about the fair processing of data. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had access to contact numbers for local safeguarding teams. The pharmacists had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. And they have opportunities to develop their knowledge. The team members share information and learning particularly from errors when dispensing. The pharmacy encourages the team members to identify areas for improvement when delivering services. And it supports team members to make changes to improve the safe delivery of the pharmacy services.

Inspector's evidence

Regular pharmacists covered the opening hours. The pharmacy team consisted a full-time qualified dispenser, a full-time trainee dispenser and a Boots relief dispenser who usually helped out once a week. The store manager, assistant manager and trainee manager were qualified dispensers. So, they could help the team when required. The team wore name badges detailing their role. At the time of the inspection two of the regular pharmacists, the qualified dispenser, the trainee dispenser and one of the assistant managers were on duty. The pharmacists sometimes worked without a dispenser. On the rare occasion a person presented a prescription during this time the pharmacist incorporated a triple check of the medicines dispensed.

The team members often joined the store manager's huddles. And the store management team promptly passed on updates from Boots to the team. Recent information included details from the NHS standard operating procedure and guidance for community pharmacy about Coronavirus. The pharmacy provided extra training through e-learning modules. Due to the limited team numbers the team did not have protected time to complete the training. The pharmacy displayed the latest publication sent from Boots Professional Standards in the dispensary for the team to read.

The pharmacy provided performance reviews for the team. The pharmacy had not had a manager for some time. So, performance reviews for the team had not recently taken place. The new manager had planned performance reviews for the team over the following weeks to give the team members a chance to receive feedback and discuss development needs. The dispenser was interested in progressing their career and discussed options such as management training and pharmacy technician training. The dispenser had taken on the role of completing the patient safety reports as part of their preparation for the additional qualifications. Team members could suggest changes to processes or new ideas of working. The dispenser who managed the compliance packs had reviewed the process for preparing the packs. The dispenser asked a relief dispenser who had not worked at the pharmacy to prepare some packs and give feedback. So, the dispenser could identity what worked well and what could be improved. The dispenser used this information to make changes and add steps to the process. This included having a list of every person who had the packs and when the packs were due to be supplied. So, anyone helping to provide the packs could see what packs had to be prepared. The pharmacy displayed a whistleblowing policy for the team to refer to if they wished to raise a concern. The pharmacy set targets for the services offered such as the New Medicines Service. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was small with limited work space. The team managed this by keeping the work benches free of clutter. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And the team used alcohol gel for hand cleansing. The pharmacy displayed notices describing effective hand washing techniques next to the sinks. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The pharmacy had a separate area to enable people collecting their methadone doses to do so in private. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. The team members manage the pharmacy services well. They identify potential issues that may affect the safe delivery of services. And they act to address them. The team members keep records of prescription requests and deliveries. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via the store entrance through an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy displayed a GPhC poster explaining what people could expect from the pharmacy. The poster included a code for people to scan using their telephone. This took the person to the GPhC inspections website. The pharmacy displayed the posters provided by HM Government and the NHS about the Coronavirus in the retail area for people to read. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy team had completed checks to identify people who met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the criteria.

The pharmacy provided multi-compartment compliance packs to help around 20 people take their medicines. People received monthly or weekly supplies depending on their needs. The qualified dispenser managed the service and divided the preparation of the packs across the month. The dispenser kept a list of people who received the packs and the date the packs were due to be supplied. The dispenser usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. A few prescriptions arrived at the pharmacy the day before supply. These prescriptions were for weekly packs. The dispenser knew which packs the prescriptions were for. So, he allowed time to prepare the packs when the prescription arrived. Each person had a record listing their current medication, dosage and dose times. The dispenser checked received prescriptions against the list. And queried any changes with the GP team. The team usually recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The team stored completed packs in large trays labelled with the person’s name and the date the supply was due. The pharmacy had a collection document for the team members to record when they had supplied the packs. The team recorded details such as the date of handing the packs out. And obtained a signature from the person collecting the packs. The team referred to the collection document when queries arose. The pharmacy sometimes received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses with the prescription in the controlled drugs cabinet in boxes labelled with the person’s name. This helped to reduce the risk of selecting the wrong one. The pharmacist marked the prescriptions to highlight details such as the sugar-free formulation. The pharmacy had a list of people who received methadone. The pharmacist marked the list to show who had received their dose. So, the team could refer to this when queries arose.

The team downloaded the electronic (EPS) prescriptions in batches in accordance to the date the supply was due. This process generated an order of the medicines on the prescription. The team placed all the processed prescriptions into tubs awaiting the delivery of the medicines from the wholesaler. And used a section of the dispensary to hold the medicine stock when it arrived. Each prescription was matched with the stock ordered and the stock and prescription were placed in to a tub. The team members used the bar codes on the prescription and the products to check they had dispensed the correct medicines. The pharmacy team used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person obtained from the electronic medication record (PMR) during labelling. These forms included dose changes or new medication. The team also used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person. For example, their latest blood test results. And the team recorded this information when it was given. The PIF stayed with the prescription until the team supplied the medication. So, everyone could refer to the information captured on the PIF. The team used the PIF to record medicines that looked and sounded alike (LASAs), as these were often linked to errors. The team members used this as a prompt to check what they had picked.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a quad stamp. The pharmacy used this as an audit trail of who had clinically checked, accuracy checked, dispensed and handed out the medication. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The local GP surgery was changing the prescription ordering system so the person had to order their own prescription with the GP surgery, not through the pharmacy. The pharmacy team members spent time with people explaining why this was happening. And they planned to use the text messaging service to remind people to order their prescriptions. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

A box of zomorph 10mg capsules had a strip of capsules that had a different batch number and expiry date to the container. So, there was a risk that the team could not check these medicines against any safety alerts that came through. And the team couldn't include these medicines in any date checks. The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 02 March 2020. The team used a caution short dated stock sticker with the expiry date written on to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Lyflex 5mg/5ml oral solution with 56 days use once opened had a date of opening of 27 January 2020 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy had scanning equipment installed to meet the requirements of the Falsified Medicines Directive (FMD). But the team were not scanning

FMD compliant packs. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via internal email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.