General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 3 - 5 St. Wilfrids Square, Calverton, NOTTINGHAM, Nottinghamshire, NG14 6FP

Pharmacy reference: 1089938

Type of pharmacy: Community

Date of inspection: 22/01/2024

Pharmacy context

This community pharmacy is in a parade of shops in the village of Calverton 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 for people. And it provides a medicines delivery service to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	Pharmacy team members cannot demonstrate how they share learning following mistakes made during the dispensing process. And they do not engage in processes designed to reduce the risk of similar mistakes happening again.
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 not all met**

Summary findings

The pharmacy doesn't always adequately manage risks to patient safety. Its team members do not suitably engage in processes designed to reflect on and learn from mistakes they make during the dispensing process. This increases the chance of a similar mistake occurring. Pharmacy team members generally make the records they need to by law. They protect people's private information appropriately. And they know how to recognise and report safeguarding concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) to support its safe and effective running. These were accessible to team members electronically through their individual learning accounts. A sample of training records demonstrated that team members engaged in regular learning that assessed their understanding of the SOPs. And there were monitoring processes to ensure this learning took place in a timely manner. A member of the pharmacy team described what tasks couldn't take place if the responsible pharmacist (RP) took absence from the pharmacy. There were some occasions when team members did not always follow SOPs. For example, they did not always take the opportunity to record a mistake made and identified during the dispensing process, known as a near miss. A member of the wider relief team demonstrated how they were informed of a near miss. And how they acted to review their work and correct the mistake themselves. But permanent team members acknowledged that they did not regularly take the opportunity to record a near miss brought to their attention. And the team could not provide evidence of how they learnt from these events. The pharmacy had a process for managing and reporting mistakes identified following the handout of a medicine to a person, known as a dispensing incident. And the RP explained how they would manage and report a dispensing incident. But team members did not have access to reporting records for either near misses or dispensing incidents. They could not recall any examples of shared learning following mistakes, and they were not familiar with any actions taken to reduce risk. There was no evidence of engagement in regular patient safety reviews taking place. And there was an absence of acknowledgement about the importance of sharing learning in this way.

The pharmacy advertised how people could provide feedback and raise a concern. And its team members had a clear understanding of how to manage feedback and escalate concerns. Pharmacy team members engaged in mandatory safeguarding learning to help protect vulnerable people. They knew how to report safeguarding concerns and what action to take if somebody attended the pharmacy using a code word promoted by national domestic violence safety initiatives to help them access a safe space.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It had processes for separating and securely disposing of its confidential waste. All team members engaged in mandatory learning on confidentiality and data security. The pharmacy had current indemnity insurance. The RP notice displayed was changed shortly after the inspection began to reflect the correct details of the RP on duty. A sample of the RP record found entries completed as required. The pharmacy kept a record of the private prescriptions it dispensed. But there were some minor inaccuracies in these records. For example, the date of prescribing was not always accurate. This meant

it may be more difficult for team members to respond to a query should one occur. The pharmacy held records for the unlicensed medicines it dispensed with supporting information about who the medicine was supplied to. The pharmacy maintained running balances in its controlled drug (CD) register. And a pharmacist completed frequent balance checks of all CDs against the balance recorded in the register. But pharmacists recording the receipt of a CD did not always include the address of the wholesaler when making the record as required. Random physical balance checks of CDs conducted during the inspection complied with the running balance in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs suitably qualified and skilled team members to deliver its services. Pharmacy team members engage in ongoing learning relevant to their roles. They know how to raise a concern at work, and they work hard together to complete the workload in a timely manner.

Inspector's evidence

The RP was a regular pharmacist who worked three days each week. The remainder of the week was covered by locum and relief pharmacists. On duty alongside the RP were two permanent dispensers, a dispenser from another local pharmacy owned by the company and a member of the local relief dispensing team. The pharmacy's manager was a dispenser and was currently on unplanned leave. The pharmacy also employed another two dispensers, one was on annual leave, and one was on planned long-term leave. It had recently employed two new team members, one of these team members worked to complete stock-replenishment tasks on the shop floor and undertook cleaning duties. They did not complete any pharmacy related tasks. The team provided examples of how it had struggled with staffing levels for some time and had seen a turnover of five managers in three years. They currently received some support from a manager of another local pharmacy. Team members discussed an event in the last week which had left one team member and the RP on duty at the beginning of the day. They explained additional support was arranged through team members from another local pharmacy arriving later to help. But they felt they were not always kept informed of contingency arrangements, so were left not knowing if additional cover had been arranged. This increased workload pressure and meant team members were distracted away from their roles whilst seeking clarification of contingency arrangements. Team members were observed working hard and workload was generally up to date. The pharmacy had some targets associated with its service. The RP reported feeling able to apply their professional judgement when delivering pharmacy services.

Team members completed regular learning to support them in their roles. They explained they generally completed this learning at home, in their own time due to how busy they were at work. They were aware that time would be made available for them to complete learning at work if they requested this. Pharmacy team members were observed communicating effectively with each other to manage workload. But they did not take regular opportunities to share learning following mistakes made during the dispensing process. This increased the chance of the same mistake, or a similar mistake being made in the future. The pharmacy had a whistleblowing policy and it advertised how team members could raise a concern confidentially if needed. Pharmacy team members understood how to raise a concern at work. And they knew how to escalate a concern if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, clean and adequately maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy premises were secure and maintained adequately. There was a clear process for reporting any maintenance concerns. The team had recently reported two concerns, and a maintenance contractor was observed attending the pharmacy as the inspection ended. The pharmacy was generally clean but there was some unnecessary clutter in a small office area to the side of the dispensary. Lighting and ventilation throughout the premises were appropriate. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. The public area was fitted with wide-spaced aisles. There were two signposted consultation rooms. But one of these rooms was used as a work area for the completion of tasks for the multi-compartment compliance pack service. The other consultation room was accessible to people. There was some clutter on workbenches within the room and this did distract from the overall professional appearance.

The dispensary was separated by a part-height partition wall. Shelves containing retail goods lined the public-facing section of the wall. This prevented people from being able to see information in the dispensary. But people were observed approaching the partition wall to speak to dispensary team members when queues formed at the counter. This increased the risk of distraction during the dispensing process. A team member explained how they would go back and start the task again should such a distraction occur. The dispensary was a good size and provided enough space for completing dispensing tasks. Team members completed some higher-risk tasks such as measuring liquid CDs and completing tasks for the multi-compartment compliance pack service in areas protected from the risk of distractions. Steps leading from the back of the dispensary led to staff facilities and storerooms.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. It obtains its medicines from reputable sources. And overall, it stores its medicines safely and securely. Pharmacy team members provide people with relevant information about their medicines to help them take them safely.

Inspector's evidence

People accessed the pharmacy through automatic doors at street level. It advertised its opening times and details of its services for people to see. Pharmacy team members knew how to signpost a person to another pharmacy or healthcare provider if they required a service which the pharmacy could not provide. The pharmacy held its Pharmacy (P) medicines behind the medicine counter. This protected them from self-selection and the RP was able to supervise activity in the public area.

The pharmacy team was aware of counselling and monitoring checks when supplying higher-risk medicines. The RP discussed the dispensing requirements related to the valproate pregnancy prevention programme (PPP), including ensuring the necessary safety information was included when supplying valproate to people. A discussion with the RP brought their attention to the requirement to physically detach and provide the valproate patient cards to people. The team used bright warning cards to inform additional checks when dispensing higher-risk medicines. And it used a colour coded system to highlight higher-risk medicines on prescriptions. For example, it used a yellow highlighter to identify CDs requiring entry into the CD register and a blue highlighter to indicate additional counselling was required when handing out the medicine. But it did not routinely record these types of interventions on people's medication records to help inform continual care.

The pharmacy had appropriate information available to support its team members in delivering its services. For example, current patient group directions (PGDs) to support pharmacists administering flu vaccinations. The pharmacy used baskets and tubs throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. 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 who had completed each stage of the dispensing process. A random sample of dispensed prescriptions found some minor gaps in these audit trails. Pharmacy team members printed a 'Pharmacist Information Form' as they labelled prescriptions. This provided some safety information to pharmacists to support their clinical check of a prescription. For example, the form flagged new medicines and information about people's allergies. The pharmacy kept original prescriptions for medicines owing to people. Team members used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy maintained an audit trail of the medicines it delivered to people. This supported team members in answering queries related to the delivery service.

The pharmacy sent some dispensing workload offsite to the company's hub pharmacy. Its processes for sending data to the hub ensured a pharmacist completed data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. But due to some workload pressures the regular pharmacist often completed the clinical check of prescriptions whilst also completing the data entry and data accuracy checks. In this circumstance there was no mental or physical break between

the entry and accuracy check of the data as it was completed as one process by the same person. This may increase the chance of a mistake during the data entry process being missed. Some prescriptions were part-dispensed locally and part-dispensed by the offsite dispensing hub pharmacy. The team used its patient medication record (PMR) system to support it in ensuring all medicines on a prescription were supplied to people. This included using barcode technology to record the storage locations of bags of assembled medicines. And to identify where a prescription was in the dispensing journey.

The pharmacy supplied some medicines to people in multi-compartment compliance packs. The team completed an assessment with people prior to supplying medicines in this way to ensure it was suitable. The pharmacy used individual patient record sheets to record people's medication regimens. And to document medicine changes when they occurred. Records included supportive information about changes, such as correspondence from hospitals. The pharmacy supplied one medicine intended for supply in the manufacturer's original pack within a compliance pack. The RP discussed how they assessed the need to supply the medicine in this way. And they had discussed this with the prescriber. But there was no documentation to support this assessment of risk. A sample of assembled compliance packs contained dispensing audit trails and descriptions of the medicines inside the packs. And the pharmacy supplied patient information leaflets when supplying medicines in this way.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, within their original packaging, on shelves. The pharmacy stored CDs within secure cabinets. Medicines inside were stored in an orderly manner. Out-of-date stock waiting to be securely destroyed was clearly labelled and stored in a separate area of the cabinet. The pharmacy stored medicines requiring refrigeration in a large pharmaceutical grade fridge. It monitored fridge temperatures, and these records showed the fridge was operating within the correct temperature range of two and eight degrees Celsius. Team members had last recorded date checks associated with the medicines held in the pharmacy in November 2023. Random checks of dispensary stock found no out-of-date medicines. Team members clearly annotated liquid medicines with information to support them in making checks to ensure medicines remained safe to supply after opening. The pharmacy had appropriate medicine waste bins and CD denaturing kits available. It received alerts about medicines through its intranet and by email. And the RP demonstrated how the team acted in a timely manner in completing relevant checks of medicines in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment in needs for providing its services. It makes appropriate checks to ensure its equipment remains safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to a wide range of digital reference sources. They used passwords and NHS smart cards when accessing people's medication records. The team stored bags of assembled medicines safely within the dispensary. This prevented people's personal information on bag labels and prescriptions from unauthorised view. The pharmacy had cordless telephone handsets. This allowed its team members to move out of earshot of the public area when speaking to people about a private matter over the phone.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicine with separate measures identified for use only with a higher-risk liquid medicine. Equipment to support consultation services was stored neatly within the consultation room. The pharmacy's equipment was regularly checked to ensure it remained fit for purpose. For example, electrical equipment was safety checked periodically.

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.