General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, The Carlton Centre, Outer Circle Road, LINCOLN, Lincolnshire, LN2 4WA

Pharmacy reference: 1091487

Type of pharmacy: Community

Date of inspection: 23/01/2023

Pharmacy context

This community pharmacy is on a retail park on the outskirts of Lincoln. It is open extended hours, including late into the evening on six days of the week. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy offers a seasonal flu and pneumonia vaccination service for 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	1.8	Good practice	Pharmacy team members recognise the importance of safeguarding people from harm. They act with care and compassion to ensure people receive the support they require. And they document the actions they take when doing this.
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	4.1	Good practice	The pharmacy team acts with care to ensure barriers to people accessing pharmacy services are overcome. It works well with other healthcare professionals to ensure people have access to medicines and supportive information outside of its core opening hours.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively identifies and manages the risks associated with its services. It keeps people's personal information secure, and it keeps the records required by law in good order. Its team members act openly and honestly by sharing information following any mistakes they make to help ensure they provide the pharmacy's services safely. Pharmacy team members work well to identify and support vulnerable people to help keep them safe from harm. And they understand how to respond to feedback they receive from people accessing pharmacy services.

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. And a control document clearly identified the SOPs relevant to each team member's role. A sample of training records demonstrated by team members during the inspection confirmed they engaged in regular learning that tested their understanding of the SOPs. Pharmacy team members had a good understanding of their roles and responsibilities. They were observed working in accordance with both dispensing and sales of medicines SOPs. And they identified and managed risks as they worked. For example, they routinely completed allergy checks with people, prior to supplying penicillin. A team member highlighted the importance of regularly sharing learning to support the safe delivery of pharmacy services. For example, by keeping up to date with reading designed to share safety information, such as monthly ‘Professional Standards’ newsletters developed by its superintendent pharmacist’s team.

Pharmacy team members engaged in regular learning following adverse events. They were encouraged to reflect on mistakes made and identified during the dispensing process, known as near misses. And they took the opportunity to record most of these mistakes on a near miss record. The team also recorded mistakes that were identified following the supply of a medicine to a person, known as a dispensing error. The pre-registration pharmacy technician led shared learning each month through a formal patient safety review. This identified trends in mistakes and set out actions to help reduce the risk of similar mistakes occurring. Pharmacy team members could demonstrate these risk reduction actions. For example, team members physically circled the quantity on medicine labels when not supplying the original pack size. Recent changes to the patient safety review template encouraged the team to revisit the actions to help monitor how they worked in practice. The timescale for doing this was yet to be established on the current review displayed in the dispensary.

The pharmacy advertised how people could provide feedback and raise a concern. Pharmacy team members were observed working together to manage queues at the healthcare counter during busy periods. And felt they had a good rapport with people. They understood how to manage feedback and 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 team had intervened on a number of occasions to help safeguard a person from harm. And it acted to report these events in line with its SOPs. The pharmacy advertised its consultation room as a 'safe space' and a team members demonstrated a good understanding 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 was displayed prominently and contained the correct details of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy kept the records required by law in good order. The team used monitoring tools to ensure key record keeping tasks such as signing into the RP record and completing weekly balance checks of controlled drugs (CDs) were completed. The pharmacy maintained running balances in the CD 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 enough, suitably skilled team members to manage its workload effectively. It reviews its staffing levels and skill mix in line with changes to its services. And it supports its team members by providing regular opportunities to engage in learning relevant to their roles. Pharmacy team members work together well. They understand how to provide feedback about the pharmacy, and they can raise a professional concern if needed.

Inspector's evidence

The RP was a regular pharmacist and had worked at the pharmacy for a number of years. Three other pharmacists worked at the pharmacy regularly. The remainder of shifts were covered by relief or locum pharmacists. The pharmacy also employed a pre-registration pharmacy technician, a trainee pharmacist, six qualified pharmacy advisors (dispensers) and three trainee pharmacy advisors. Both the store manager and assistant manager were also qualified pharmacy advisors. The pharmacy had reviewed its staffing levels and skill mix in line with demand for dispensing services increasing during the pandemic. Pharmacy team members reported a period of heightened workload pressure within the last year. This was due to workload growing during the pandemic and staff absence. They reported being in a much better place now, and workload was seen to be well organised an up to date.

Pharmacy team members enrolled on accredited training received some time in work to support their learning. Training time had been reduced during periods of heightened pressure. But this had been reintroduced once staffing levels were back to normal and the demand for the seasonal flu vaccination service had reduced. All team members received time to complete learning related to SOPs and pharmacy services. The trainee pharmacist confirmed they felt supported at work, and they received regular learning time. Pharmacy team members were supported through a structured appraisal process.

The pharmacy had some targets associated with its services that the team was expected to meet. For example, the number of flu vaccines it administered. A discussion with the RP confirmed they were able to apply their professional judgement when providing pharmacy services. And they received support from managers in balancing dispensary workload with other pharmacy services. Pharmacy team members engaged in continual discussions related to patient safety and risk management. They demonstrated a good awareness of key risks during the dispensing process. For example, the need to fully utilise safety tools built into the patient medication record (PMR) system to support them when dispensing. And they were observed working together well to manage workload. The pharmacy had a whistle blowing policy and it advertised how its team members could provide feedback or raise a concern at work. Pharmacy team members spoken to understood how to raise feedback and how to escalate a concern at work.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and clean. They include a suitable private consultation space. The pharmacy generally keeps its premises well maintained. But it does have some unresolved concerns relating to the temperature of the dispensary in winter months. This may increase the chance of team members being distracted from their work.

Inspector's evidence

The pharmacy was secure and adequately maintained. Pharmacy team members understood how to report maintenance concerns. Air conditioning was provided at store level, but there was no vent close to the pharmacy area. Pharmacy team members reported that it was particularly cold during winter months, and they had raised concerns about the level of heating in the pharmacy area. The team wasn't actively recording room temperature, so it was not known how cold the environment was during periods of winter weather. It had been provided with a portable fan heater to help improve the working environment. But team members explained this was loud and affected their concentration and the ability to hear phone calls. This meant it was not practical for them to work with the heater on. Lighting throughout the premises was bright. The pharmacy was clean, and floors were free of trip hazards. 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. The dispensary was fitted with separate workstations, each suitably equipped to support the dispensing process. The pharmacy's consultation room was clearly advertised and available for use when people requested a quiet conversation with a team member. The room was clean and professional in appearance. Shelving had been fitted over a service hatch leading from the dispensary to the public area. This was due to the significant increase in workload over the last few years. The team had adapted to provide some services, previously conducted at the hatch, in the consultation room and in a quiet area of the store located directly alongside the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy works particularly well to promote access to its services across its extended opening hours. And it uses effective measures to help ensure the communication needs of people accessing its services are met. It obtains its medicines from reputable sources. And it stores them safely and securely. The pharmacy team identifies higher-risk medicines to help make sure people taking these medicines have the support they need. And it provides relevant information when supplying medicines to help people take them safely.

Inspector's evidence

People accessed the pharmacy through an automatic door from the carpark. The pharmacy clearly advertised its opening times and details of its services for people to see. This included details of how people could access its out-of-hours services, provided through a service hatch at the front of the premises. And important information about parking arrangements when people visited the pharmacy late in the evening. Uptake of services outside of core opening times was significant. The RP spoke a second language and provided a recent example of how this had helped a person access the pharmacy's services. Team members also used computer software to support them in communicating with people who did not speak or understand English well. They were observed providing clear information to people about the pharmacy services provided, including the NHS New Medicine Service (NMS). Pharmacists regularly engaged with people through the Community Pharmacist Consultation Service (CPCS). Pharmacy records showed a large uptake of referrals to the pharmacy from NHS 111 and GPs. And the RP reflected on the support and assistance provided to people through this service.

The team reflected on the use of serious shortage protocols (SSPs) to support the supply of antibiotics during the recent wave of streptococcal A infections. It had completed learning associated with supplying solid dose antibiotics for use in children. This included ensuring the appropriate size syringe and the correct information and necessary equipment was provided to support carers needing to crush or dissolve tablets. 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. The pharmacy's flu vaccination had been very popular. The trainee pharmacist had undertaken the necessary training to support the delivery of this service. Pharmacists had access to up-to-date and legally valid patient group directions to support the flu and pneumonia vaccination services. The trainee pharmacist administered vaccinations through the pharmacy's private flu vaccination service.

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. A member of the wider store team was observed brining a query about a vitamin supplement to the attention of the RP who made time to speak with the person directly. Team members were observed managing requests for P medicines with care and providing advice and information in accordance with the pharmacy's sales of medicines procedures. 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 that it attached to prescription forms until the point of hand-out or delivery. And the

team followed prompts on the back of the cards to inform counselling. The team recorded information relating to these checks on people's medication records. It had recently engaged in a valproate safety audit to support the requirements of the valproate Pregnancy Prevention Programme. Part of the audit included ensuring the pharmacy documented details of conversations related to the person's annual specialist review status. And ensuring it issued patient cards and appropriate information when supplying valproate to people within the at-risk group.

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 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 a sample of prescriptions identified that 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 team used tubs and trays when dispensing medicines to separate individual people's prescriptions to avoid items being mixed up. It retained prescriptions for owed medicines, and 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. And it contacted people by telephone to arrange deliveries and to provide any counselling required.

The pharmacy supported access to medicines in a number of ways. It dispensed some medicines to people daily to help safeguard them from harm. And it ordered prescriptions for some people who struggled to do this themselves, including those who received their medicines in a multi-compartment compliance pack. The pharmacy used a progress record and communication diary to support it in managing the compliance pack service. It kept individual patient profile sheets up to date with details of people's medication regimens. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of each medicine inside the packs. And patient information leaflets were provided at the beginning of each four-week cycle of packs. The pharmacy sent some of its workload to the company's offsite hub pharmacy. A team member demonstrated effective processes and audit trails for the transfer of prescription data to the hub. This included ensuring prescriptions were clinically checked by a pharmacist and monitoring the accuracy of the data sent to the hub. Team members used barcode technology to track prescriptions. And they matched together bags of 'locally dispensed' items with bags of items from the hub. This mitigated the risk of people only being supplied with part of their prescription.

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. For example, it kept fridge temperature records to show that its fridges were operating within two and eight degrees Celsius as required. And it kept records of its date checking activities. 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 fit to supply. The pharmacy stored CDs in secure cabinets and storage of medicines within each cabinet was organised. A separate cabinet was used solely to hold patient-returned and out-of-date CDs. And the bags of waste medicines inside this cabinet were clearly labelled. The pharmacy had two medical fridges and it held medicines inside each fridge in an orderly manner. The pharmacy had medicine waste bins and bags, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. It received medicine alerts electronically through the company intranet. And it kept a record of the actions taken in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to ensure it remains safe to use. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

The RP demonstrated how to access to an online subscription service the pharmacy used to provide team members with access to a wide range of 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 a cordless telephone handset 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 equipment to support it in delivering the pharmacy's services. This included appropriate equipment for counting and measuring medicines. Team members used separate equipment 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 annotated with information relating to periodic safety 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.