

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, D80, Bay 71 D80 Warehouse, Harrimans Lane, NOTTINGHAM, Nottinghamshire, NG7 2SD

**Pharmacy reference:** 1096181

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 01/08/2023

## Pharmacy context

The pharmacy is open seven days a week and is located at the company's head office site in Nottingham. Its main service is dispensing private prescriptions for the Boots Online Doctor service, which is provided by a Care Quality Commission (CQC) registered online healthcare provider. The pharmacy operates its dispensing service through a distance-selling model. This means people do not visit the pharmacy premises and instead receive their medicines through a postal delivery service. It also provides a private hepatitis B and flu vaccination service to people working at its head office site.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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 |
|--|-------------------|------------------------------|------------------|-----|
| <b>1. Governance</b>                               | Standards met     | N/A                          | N/A              | N/A |
| <b>2. Staff</b>                                    | Standards met     | N/A                          | N/A              | N/A |
| <b>3. Premises</b>                                 | Standards met     | N/A                          | N/A              | N/A |
| <b>4. Services, including medicines management</b> | Standards met     | N/A                          | N/A              | N/A |
| <b>5. Equipment and facilities</b>                 | Standards met     | N/A                          | N/A              | N/A |

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy generally identifies and manages the risks associated with its services well. Its management team works closely with the associated prescribing service to monitor these risks. The pharmacy responds appropriately to feedback people raise about its services. It keeps the records required by law in good order and it manages people's confidential information securely. Pharmacy team members have the knowledge to recognise and raise safeguarding concerns. And they engage well in processes designed to share learning and reduce risk following the mistakes they make during the dispensing process.

### Inspector's evidence

The pharmacy was associated with a CQC registered prescribing service. The service was advertised as 'Boots Online Doctor.' The prescribing service employed a chief medical officer, a number of GPs, as well as pharmacist and nurse independent prescribers. The pharmacy's superintendent pharmacist's (SI's) office worked directly with the prescribing service in monitoring and developing the service. This work included fortnightly clinical review meetings which the pharmacy's regular pharmacists attended. The service moved to this pharmacy in June 2022.

The pharmacy had a risk register in place that covered a wide range of potential risks and actions to reduce and mitigate these. This included risks of fulfilment for the prescribing service. A separate register considered the risks associated with a new weight loss service provided by the pharmacy. It reviewed the risk registers periodically, and these were version controlled. The SI's team had sought assurances that the prescribing service had assessed the risk of each medicine it prescribed. And it had satisfied itself that clinicians working for the prescribing service had been provided with this information to support them in prescribing safely. But the pharmacy team did not have access to this information to support pharmacists in their clinical decision making. Pharmacists often relied on other methods for obtaining further information when required. For example, obtaining specific 'treatment plans' which consisted of information about the medicines prescribed. But these did not contain information to support pharmacists in understanding how prescribing decisions were made. Pharmacists communicated regularly with clinicians via a web-based messaging channel. A record of this communication was kept which meant any team member could follow up on a query if required. A pharmacist indicated that response times through the channel were generally quick. There was evidence of the pharmacy cancelling a prescription and informing the prescribing service of this decision when a query was not answered within 72 hours. Another example showed the pharmacy querying a duplicate order for a supply of medicine used to treat erectile dysfunction. The prescribing team cancelled the duplicate order appropriately. Pharmacists also had access to a service summary sheet. This was used as part of the clinical screening and checking process. The service summary sheet included information about the treatments prescribed including descriptions of medical conditions and the age range that it would be suitable for. But it did not provide details about maximum quantities that should be supplied for certain treatments. Regular pharmacists provided examples of seeking this information to support their own professional decision making when carrying out their checks. For example, the service prescribed Saxenda, an injectable medicine used for weight loss. The RP indicated that they would usually supply a box of five injections in one period. But they were aware the maximum they could supply was ten. The RP stated that a repeated order within the current period would result

in contact with the prescribing team and evidence of this was seen.

The pharmacy had a range of current standard operating procedures (SOPs) relevant to its services. These included specific SOPs associated with dispensing prescriptions through the online doctor service. Pharmacy team members were observed following the SOPs when carrying out activities. For example, taking accountability for their work by completing an audit grid on each prescription when completing each stage of the dispensing process. The pharmacy completed a weekly clinical governance audit. This focused on ensuring the team was up to date with key tasks associated with record keeping, recording adverse events and stock management. Weekly clinical governance meetings also took place between the RP and pharmacy manager. The pharmacy had engaged in a pharmacy standards audit in March 2023. This audit was based upon the GPhC's premises standards. It clearly considered the nature of the services provided. And the audit had highlighted some actions, some of which had yet to be fully implemented. But it had not carried out any clinical audits to date. And pharmacists were not aware of any clinical audits or prescribing reviews that had taken place of the online prescribing service. Following the inspection, the SI's office advised that the prescribing service provided assurance of monthly audits in compliance with prescribing policies. But information from these audits was not directly shared with the pharmacy team.

The pharmacy had tools to support its team members in recording mistakes found and corrected during the dispensing process, known as near misses. The pharmacy's reporting rates were consistent and team members were knowledgeable about recent actions implemented to help reduce risk. For example, by double checking directions on prescriptions when producing labels. Team members also recognised the importance of using safety tools embedded within the patient medication record (PMR) system when dispensing medicines. For example, by scanning individual packs of medicines to confirm they had selected the correct medicine. Pharmacy team members understood how to respond to, and report mistakes identified following a person receiving their medicine, known as dispensing incidents. And the pharmacy kept dispensing incident reports with details of the outcome of the investigation and the actions taken to reduce the risk of a similar incident occurring. A pharmacist demonstrated how the team had changed the process for printing shipping labels following a trend in incidents involving incorrect shipping labels applied to boxes. It had monitored the effectiveness of the action and was planning further changes as a result of this monitoring process.

The online doctor website provided clear information about how people could provide feedback or raise a concern about all aspects of the service. A frequently asked questions section of the website provided people with the opportunity to speak to a pharmacist from the Boots online prescription service team if needed. But the main route of feedback to the pharmacy was through the prescribing service's customer service team. The RP shared an example of how the pharmacy and prescribing service had worked together to ensure a person received a replacement topical preparation following a concern about a faulty canister. Following some feedback about its delivery service, it had reached out to its suppliers to arrange delivery of sturdier boxes. And it had implemented interim measures to reduce the risk of packages becoming damaged whilst waiting for delivery.

The pharmacy had current indemnity insurance. The RP notice was clearly displayed with the correct details of the RP on duty and the RP record was completed as required. The pharmacy held its private prescription register electronically. A sample of entries within the register were completed in accordance with legal requirements. The pharmacy received prescriptions from the prescribing service through a secure portal which encrypted the PDF prescription files. The prescriptions contained advanced electronic signatures applied directly by prescribers.

The pharmacy had specific procedures relating to information governance and data security. It held people's confidential information securely and disposed of confidential waste appropriately.

Information held electronically was regularly backed up. The online doctor website contained details of its privacy policy for people to read. The prescribing services identification check requirements varied for individual services and pharmacists had some knowledge of the checks for the range of services provided. The pharmacy had assured itself that the prescribing services approach to patient identification checks was proportionate to the level of risk for each service and in line with national guidance such as joint the 'Standards for Online and Remote Providers of Sexual and Reproductive Health Services' published by the Faculty of Sexual Health & Reproductive Healthcare of the Royal College of Obstetricians & Gynaecologists (FSRH) and the British Association for Sexual Health and HIV (BASHH). A regular pharmacist shared details of an intervention they had made when a person accessing the contraceptive service appeared to be under the age of 16. This had prompted pharmacists to seek their own assurances through testing the patient pathway. A pathway tested was the weight loss service. A pharmacist described how identity was checked at the beginning of the consultation by the upload of an identity document containing a photo and the person was also required to take a picture of themselves holding the document.

The pharmacy had procedures for safeguarding vulnerable people. And contact information for safeguarding teams was accessible. People needed to be 16 years or above to access the prescribing service and the pharmacy checked the age on prescriptions. The pharmacy was assured that treatments for mental health and wellbeing were only prescribed by the prescribing service following a video or telephone consultation. This provided an additional safeguard to potentially vulnerable people. And the online doctor webpage for depression and anxiety signposted people experiencing a mental health crisis, or at risk of self-harm or suicide to relevant healthcare and support services. Pharmacists knew how to report a safeguarding concern, this included liaising with the prescribing service to share details of the concern. They provided examples of these types of concerns such as querying a prescription for a contraceptive pill when the person's gender was not clear. And making additional checks with the prescribing service when a contraceptive pill was switched within a shortly following the last prescription.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

Pharmacy team members actively engage in continual learning opportunities designed to improve patient safety. They have regular opportunities to provide feedback. And they are aware of how to raise professional concerns. The pharmacy regularly reviews its staffing levels and skill mix to ensure they remain appropriate. It provides its team members with support to complete ongoing learning associated with their roles. Pharmacists benefit from the opportunity to reflect on their own personal development and performance at work. But the pharmacy does not extend this structured support style to the rest of the team.

### Inspector's evidence

A pharmacy manager supported the team in an operational role, they did not hold any pharmacy qualifications and as such did not complete any dispensing related tasks. The manager was supported by an assistant manager who was enrolled on an accredited GPhC training course relevant to their role. The pharmacy continually reviewed its staffing levels and skill mix. The team had grown significantly since the last inspection in November 2022. It included regular pharmacists, a pharmacy technician working in an accuracy checking role (ACPT), qualified and trainee dispensers and warehouse operatives and cleaners. The warehouse operatives were responsible for the replenishment of consumables. The RP on duty was a regular pharmacist and was working alongside another regular pharmacist and a locum pharmacist. The locum pharmacist had received appropriate training when they had begun to work at the pharmacy. This included learning relevant to their own role and shadowing tasks completed by other team members. The pharmacy had suitable business contingency arrangements to support it in managing its services. This included being able to switch off the 'home delivery' option on the online doctor website. This meant people using the service would only see an option to pick up their medicine at a Boots pharmacy local to them.

Team members received some learning time at work, those on training courses received additional learning time and felt supported in their training roles. Pharmacists had the opportunity to feedback and review their learning and development at regular intervals through a formal appraisal process. But other team members explained they did not have this opportunity as they had not received an appraisal at work. The SI's office had previously provided information about how it had assured itself of the training arrangements for prescribers working for the online doctor service. This included tailored assessments and continual learning. The pharmacy had key performance indicators to help ensure it dispensed prescriptions in a timely manner. Screens in the dispensary displayed current workload associated with ambient dispensing and cold chain dispensing separately. This supported the team in managing this target. There was evidence of the RP and other pharmacists feeling empowered to exercise their professional judgement and challenge decisions made by prescribers. An example of this involved a prescription for acetazolamide used off-label for altitude sickness, prescribed for a person over the age of 65. The RP explained the summary sheet from the prescribing service stated that it could only be supplied to people under the age of 65 and so queried this prescription. Although the prescriber was happy to prescribe this medicine the RP did not feel comfortable to dispense the medicine with the information they had and as such declined the prescription. This was documented on the PMR. Pharmacists expressed that the management team was supportive of their professional judgement when these types of interventions took place.

The ACPT demonstrated how they used their professional judgement when completing accuracy checks of medicines. This included examples of referring queries to a pharmacist and using learning to help inform their own checking process. Pharmacists kept an intervention record and consistently recorded the interventions they made regarding prescriptions they received from the prescribing service. And they fed back appropriate trends in fortnightly meetings with the prescribing service. These meetings also provided an opportunity to discuss trends and concerns. Pharmacists felt able to provide feedback in these meetings and share ideas to improve patient safety. For example, they had highlighted the benefits of including full directions on prescriptions for asthma inhalers, rather than use 'use as directed.' And the prescribing service had implemented this change. The RP shared examples of topics they wanted to discuss in the next meeting. This included strengthening their understanding of the prescribing services processes when somebody changed their address before the prescription was dispensed by the pharmacy. The manager led regular team briefings these related to the management of workload, and changes to services. Team members also engaged in regular patient safety reviews and could demonstrate the actions they took to reduce risk. The pharmacy also engaged in monthly clinical governance meetings with the prescribing service. And the team was able to access minutes from these meetings. The pharmacy had a whistleblowing policy and it advertised details of a confidential employee assistance programme. And team members spoken to felt confident in providing feedback and knew how to raise a concern at work.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean, hygienic, and secure. The online doctor website is professionally laid out and information on the website is clear and easy to understand. People begin their consultation from the medical condition they are seeking treatment for in line with GPhC guidance.

### Inspector's evidence

The pharmacy premises were secure from unauthorised access. They were clean and maintained to an appropriate standard. The pharmacy monitored its room temperatures to ensure it kept medicines in an ambient environment, it had suitable heating and ventilation systems to support it in doing this. Lighting throughout the premises was sufficient. The premises consisted of a reception area, a consultation room, staff facilities, storage areas and a dispensary. The dispensary was spacious with two distinct workflows for dispensing ambient and cold chain medicines. The consultation room was a good size and equipped suitably to provide the vaccination services. A pharmacist was holding telephone consultations associated with the NHS New Medicine Service (NMS) in the room during the inspection. The room provided ideal privacy to conduct these consultations. When a vaccination service was running colleagues working across the head office site reported to the pharmacy's reception when attending for a vaccination and they were escorted to and from the consultation room.

People accessed the online doctor service through a dedicated website. A frequently asked questions section of the website provided information to people about the pharmacy if they chose to receive their medicine via the 'deliver to me' method. This information included the pharmacy's registration number and details of how to check the registration of the pharmacy. It also included the name of the superintendent pharmacist but did not provide their registration number or details of how to check their registration. People began a consultation from the conditions page in line with GPhC guidance.



## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy ensures its services are accessible to people. It obtains its medicines from reputable suppliers. And it regularly assesses how it stores its medicines. The team complete regular checks of medicines to make sure they are fit to supply to people. Pharmacists show how they make meaningful interventions when supplying medicines. But there is a reliance on pharmacists being pro-active in seeking out further information to support their own clinical checks rather than having supportive information readily available to them.

### Inspector's evidence

People accessed the private online doctor service through a website, for a limited range of conditions. And the pharmacy supplied the medicines for people who selected home delivery. The consultations were mostly questionnaire based, with the exception of some (such as mental health conditions which required a telephone or video consultation). A frequently asked questions section provided further information about the service and timescales associated with the service. The website promoted collection from a Boots Pharmacy as the fastest option to people. And some medicines were only available in this way. These currently included medicines where people were required to take them immediately. The pharmacy was not involved in any processes where the medicine was supplied by a local Boots pharmacy. Pharmacists did not routinely have direct contact with people to counsel or signpost them to relevant services if needed. The RP explained counselling and safety netting was provided by the prescribing service through treatment plans generated for each medicine and sent directly to the person. The pharmacy held treatment plans for some but not for all of the medicines it supplied. Pharmacists explained that treatment plans were only provided if they requested them. This meant the amount of information to support pharmacists making their checks differed between treatments.

The pharmacy dispensed some medicines to help people lose weight. One of these medicines, Saxenda, was in short supply nationally. To help manage supply issues, the prescribing service did not offer Saxenda as a treatment option to any new people accessing the weight loss service. Additionally, the company had daily meetings with the prescribing service to determine quantities available throughout the company. The home delivery option for this medicine was switched on only if the pharmacy had enough stock to fill prescriptions. The pharmacy had sought assurances around the prescribing of medicines requiring ongoing monitoring such as weight loss treatments. These assurances included identification checks at each prescribing, regular body mass index (BMI), height and weight checks both at the start and during treatment to ensure the treatment remained appropriate. The prescribing service also contacted people by telephone or messaging service if further information was required. This was followed up by regular emails and weight updates and access to weight loss webinars run by a dedicated lifestyle team. The pharmacy did not have access to full consultation records or any communications the prescribing service made with a person's general practitioner. The RP stated that they had requested this access from the prescribing service but had not succeeded in getting access. A recent pharmacy standards audit had also identified the benefits of the pharmacy having access to key information such as BMI to help inform the pharmacist's clinical check of each prescription. But this had not been implemented into practice.

The pharmacy had sought assurances about how the prescribing service shared information with people's own GPs. For example, it was aware people were required to provide mandatory consent for the prescribing service to contact their own GP when accessing Saxenda and knew that ongoing consent was required to contact people's own GPs each time this medicine was prescribed. And for some other treatments such as medicines for asthma and oral antibiotics, it was aware the prescribing service required people to consent for their GPs to be informed by the second consultation, meaning that people could only receive one course of treatment before their regular GPs were made aware. Pharmacists were not aware of how the online prescribing services picked up any issues such as early ordering. They demonstrated examples of their own documented interventions involving repeat supplies of medicines within a brief period of time. For example, a person was prescribed five Saxenda injection pens and another five 11 days later. The prescriber confirmed the person was going on holiday and required this supply. A response to a similar query had resulted in a 'please issue' message from the prescriber without further explanation. And the pharmacist had not queried this further to support their clinical check of the prescription. Pharmacists kept records of all the interventions they made. The RP discussed repeat prescribing for certain treatments. This included orlistat where a prescription could be repeated three times, finasteride where prescriptions could be repeated 12 times and for contraceptive medicines, which could also be repeated 12 times. This was referred to as token dispensing. The RP highlighted that people's repeat prescriptions were only valid for one year and if the number of prescriptions had not been claimed in the year the remaining prescriptions would be cancelled and the person would need to carry out a consultation again. They also explained that the pharmacy supplied certain medicines as a large quantity, up to a year's supply. This included medicines such as finasteride for hair loss and contraception. But they were not aware of what follow up and monitoring the prescribing service carried out when larger quantities of medicines were supplied. Following the inspection, the SI's office provided further information about how the prescribing service used people's individual records. This included the option of sending follow-up information to people.

The pharmacy viewed prescriptions on a separate portal to its PMR system. Team members printed a copy of the prescription to begin the dispensing process. They generated a pharmacist information form (PIF) during the dispensing process. The PIF was attached to prescriptions and included information about the person's allergy status, and general contraindications. The dispenser also recorded the age of the person on the prescription for the pharmacist to check against the service summary sheet. And they recorded previous dispensing history to help inform the pharmacist's clinical check. Pharmacy team members took ownership of their work by completing audit grids on prescriptions to identify who had labelled and assembled the medicine, who had clinically checked the prescription, who had accuracy checked the medicine, and who had packaged the medicine ready for delivery. Pharmacy team members also signed the 'dispensed by' and 'checked by' boxes on medicine labels as part of the dispensing process. They used trays to keep different people's prescriptions and medicines separate. They processed one prescription at a time at their workstation and workflow was efficient. A separate area was used to dispense Saxenda due to it needing to remain refrigerated. Time to complete the dispensing process for this medicine was managed well and the completion of tasks was monitored to ensure the medicine remained safe and fit to supply. Medicines were delivered to people in boxes via tracked post. The pharmacy had completed a range of checks to ensure the packaging it used to send cold chain medicines kept the medicine cool. An incident involving the postal carrier had resulted in delayed deliveries of Saxenda on one occasion. A pharmacist discussed how the team had managed this to ensure the medicine remained safe to use, or a replacement prescription generated and dispensed.

The pharmacy obtained its medicines from licensed wholesalers. It stored medicines in an orderly manner throughout the pharmacy. Medicines requiring cold storage were held in medical fridges. These fridges had data trackers and the pharmacy kept a temperature record to show that it kept medicines subject to cold storage between two and eight degrees Celsius as required. It had also considered the risks of storing large quantities of a treatment supplied in an aerosol canister and had put additional

safety measures in place for storing these large quantities. This included a separate flameproof cabinet. The pharmacy followed robust date checking processes and it kept records of the checks it made. A random check of medicines found no out-of-date medicines and short-dated medicines were identified. The pharmacy had medicinal waste bins for disposing of out-of-date and damaged medicines. These were collected through a private waste contractor.

The pharmacy received emails of drug alerts electronically. It kept an audit trail to confirm the team checked and actioned the alerts. Pharmacists provided examples of how they managed concerns about medicines. For example, people reporting faulty Saxenda pens were asked to attend a nearby Boots pharmacy to establish whether the pen was faulty or whether a person needed support using it. There was a flow chart to support this. But this did not include a need for the community pharmacy to send any suspected faulty pens to manufacturers for investigation or for either pharmacy to report through the Medicines and Healthcare products Regulatory Agency's Yellow card scheme.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services. It maintains its equipment to ensure it remains in safe working order. And its team members use the equipment appropriately.

### Inspector's evidence

Pharmacy team members had access to electronic reference resources. For example, the British National Formulary (BNF). And they could access the internet and company intranet to help resolve queries and to obtain up-to-date information. Electrical equipment was in good working order with regular monitoring checks taking place to ensure it was safe to use. Pharmacists providing vaccination services had access to appropriate equipment to support these services, including medicines used to treat an anaphylactic reaction.

The pharmacy's computer systems were password protected and information was regularly backed up. Access to the premises was restricted and as such people's personal information was protected. The pharmacy stored packages of assembled medicines waiting for dispatch securely. And full audit trails supported the handover process between the pharmacy and the mail courier.

### 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.  |