General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, Unit 4D, Victoria Business Park, Netherfield, NOTTINGHAM, Nottinghamshire, NG4 2PE

**Pharmacy reference:** 1101108

**Type of pharmacy:** Community

**Date of inspection:** 04/07/2024

## Pharmacy context

This community pharmacy is on a retail park on the outskirts of Netherfield, a town in Nottinghamshire. It is open seven days a week. The pharmacy's main services include dispensing prescriptions and selling over-the-counter medicines. The pharmacy offers a range of NHS consultation services including the New Medicine Service (NMS), blood pressure check service and Pharmacy First service.

## 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 |
|---|---|---|---|---|
| **1. Governance** | Standards met | N/A | N/A | N/A |
| **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 met

### Summary findings

The pharmacy effectively identifies and manages the risks for the services it provides. It holds people's confidential information securely, and it keeps its records as required by law. Pharmacy team members understand how to listen to and respond to feedback they receive from people using the pharmacy's services. They have the knowledge to support them in identifying and reporting safeguarding concerns to help keep vulnerable people safe from harm. And they act openly and honestly by sharing learning following the mistakes they make during the dispensing process and through making effective changes to reduce risk.

### 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 SOPs were reviewed on a two-year rolling cycle or sooner if there was an identified change in process. And the pharmacy's superintendent pharmacist's (SI's) team introduced new SOPs to support the implementation of new services. The responsible pharmacist (RP) demonstrated a recently updated SOP to support the team in completing safety checks when handing out higher-risk medicines requiring ongoing monitoring. Both team members on duty demonstrated their training records which showed the were up to date with their SOP learning. One of the team normally worked at another of the company's pharmacies and had never worked at the pharmacy before. They were observed working confidently and following the SOPs when completing tasks despite being unfamiliar with the pharmacy. And they had a clear understanding of the activities that could not take place if the RP took absence from the pharmacy.

The pharmacy had a process for managing mistakes made and identified during the dispensing process, known as near misses. The RP explained how team members were encouraged to record details of their own near misses. The pharmacy team recorded the mistakes it identified following the supply of a medicine, known as dispensing incidents. It recorded the steps it took to investigate the root cause of an incident, and the learning and actions taken by the team to reduce the risk of a similar mistake occurring. To help reduce mistakes during the dispensing process, team members used a number of safety tools within the pharmacy's patient medication record (PMR) system when dispensing medicines. This included a need to scan barcodes on medicine packaging during the dispensing process to confirm they had selected the correct medicine. If a medicine was not recognised by the PMR system, the team member alerted the pharmacist that it could not be scanned and required extra care. The pharmacy team also used safety information provided by its SI's team through regular newsletters and emails to inform its approach to patient safety. A pharmacy technician led a monthly patient safety review with clinical support from the regular pharmacist. The review involved identifying trends in mistakes and acting to reduce risk. The team monitored the actions it had committed to take and these were only signed-off as complete once there was enough assurance they had been sustained. For example, an action about the need to clearly mark split packs of medicines to reduce the risk of quantity errors occurring had been kept under review for several months to ensure the action was fully implemented by all team members. Recent reviews also showed there was a commitment to encouraging team members to report their near misses.

The pharmacy advertised its feedback and complaints process to people using its services. Information

inviting people to leave online feedback about the pharmacy was available both at the medicine counter and at the prescription counter. A pharmacy team member explained how they would manage feedback and escalate a concern to the RP or manager when required. They knew to provide details of the pharmacy's head office should a person wish to escalate their concern further. All pharmacy team members completed mandatory safeguarding learning to help protect vulnerable people. The RP had completed level three safeguarding learning and provided an example of how they had sought peer support from the SI's office when reporting a safeguarding concern. All safeguarding concerns were documented on the pharmacy's incident reporting system. The pharmacy advertised its consultation room as a safe space. And the team knew what steps to take to ensure this safe space was available to people requesting access to it.

Team members engaged in mandatory learning on confidentiality and data security. The pharmacy held all personal identifiable information in staff-only areas. It segregated confidential waste and securely disposed of this. The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of the RP record, the private prescription register, and the controlled drug register were checked and complied with legal requirements. The pharmacy maintained running balances in the CD register and completed full balance checks of physical stock against the register balance frequently. Random physical balance checks of CDs conducted during the inspection matched with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy employs a team with the appropriate skills and knowledge to deliver its services. It keeps its staffing levels and skill mix under review. Pharmacy team members engage in ongoing learning relevant to their roles. They take regular opportunities to share learning and information to support them in managing workload and minimising risk. And they understand how to provide feedback should they have a concern at work.

### Inspector's evidence

The RP was the pharmacy's regular pharmacist, they worked three days a week. A regular relief pharmacist worked at the pharmacy two days a week with the remainder of the hours covered by a mix of relief and locum pharmacists. The pharmacy also employed a part-time pharmacy technician and three part-time qualified dispensers. The store manager was also a qualified dispenser. There was a current vacancy for a part-time dispenser. The pharmacy's workload was increasing, and the RP felt this was being addressed appropriately through regular staffing and skill mix reviews. A member of the wider store team had been identified to commence an accredited training course to allow them to extend their role and provide support on the medicine counter. The RP explained normal staffing levels would be the RP and either one or two other team members. But on the day of inspection there was both planned leave and unplanned leave within the team and the store manager was not on duty. The RP had raised an urgent request for assistance upon commencing their shift. And they had restricted activities until the second team member had arrived to support them. The RP felt this was an unusual situation and described the normal flexibility with the team to support cover for leave. Workload was up to date and both the RP and dispenser were observed working well to support each other in delivering the pharmacy's services safely and effectively.

The pharmacy had some targets for the services it provided. The RP discussed these targets and had a positive attitude to delivering pharmacy services that were of benefit to people. Team members completed regular learning associated with their roles and they engaged in a formal appraisal process to support their ongoing learning and development needs. The RP discussed how they worked with the pharmacy technician to help support the safe running of the dispensary. Pharmacy team members had access to a professional support telephone advice service and to an employee assistance programme. The pharmacy had a whistle blowing policy. The RP knew how to raise and escalate concerns and demonstrated how they had felt confident in raising the urgent need for support on the day of inspection. Team members shared information through regular team briefings. They recognised that not all team members could be at each briefing due to shift patterns. The team documented formal discussions such as patient safety reviews And it used a secure messaging application to share information between shifts.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is secure, clean, and generally well maintained. People wanting to speak to a pharmacy team member in confidence have access to a suitable private consultation space.

### Inspector's evidence

The pharmacy was secure and generally well maintained. A fitting on some blinds used to cover the Pharmacy (P) medicine display when the pharmacy was closed was broken. This meant team members had to deploy some of the blinds and roll them up by hand. The team reported that the durability of the blinds was poor, and that the maintenance team had replaced some of the blinds several times. Heating and ventilation arrangements were appropriate. Lighting was bright throughout the premises. The pharmacy was clean and tidy. Pharmacy team members had access to sinks equipped with antibacterial hand wash, sanitiser gel and paper towels in both the dispensary and consultation room.

The pharmacy consisted of the medicine counter, dispensary, and consultation room. Team members managed the space in the dispensary well with designated areas for completing different tasks. The pharmacy's consultation room was a good size and was accessible to all. It was clean and professional in appearance and was observed being used when providing consultation services.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from licensed sources. Overall, it stores its medicines safely and securely. And its team members make regular checks to ensure medicines are safe to supply to people. Pharmacy team members work together effectively to manage the delivery of pharmacy services. And they take the time to have supportive conversations with people to help them look after their health and wellbeing.

### Inspector's evidence

People accessed the store through automatic doors at street level. The pharmacy was signposted from the entrance for people to see. It clearly advertised its opening times and details of its services. There was good uptake of its consultation services. For example, people accessed treatment and advice for minor illnesses through the NHS Pharmacy First service regularly. The RP reflected on positive outcomes for people through this service, including ensuring they had the time to ask questions about their illness during a consultation. And the ability to provide people with immediate treatment to support them in managing their illness at weekends when some other healthcare services were limited. Pharmacists had access to supporting information such as current patient group directions, service specifications and clinical pathways to support the supply of medicines through the NHS Pharmacy First service. The pharmacy team promoted the NHS blood pressure check service to eligible people through conversation with them when they attended the pharmacy. Team members understood the importance of signposting people to other healthcare providers or pharmacies when needed.

The team was exceptionally busy throughout the inspection. Team members were observed supporting people in an attentive manner, taking time to answer their queries and provide them with treatment options and helpful information to support people in making an informed decision about their care needs. The pharmacy held its P medicines behind the medicine counter. Team members recognised the importance of monitoring requests for higher-risk P medicines subject to misuse. And they referred repeat requests to a pharmacist. The team made appropriate checks when supplying higher-risk medicines requiring ongoing monitoring. It did this through prompts on its PMR system and on its handheld scanning devices. The prompts provided helpful information to team members to support the supply such as, details of the expiry date of CD prescriptions and counselling requirements when handing out higher-risk medicines. Prescriptions for children and those flagged by the pharmacist for specific interventions were manually highlighted using laminated cards attached to bags of assembled medicines. The team made records of the checks and advice given when supplying higher-risk medicines on people's PMR to support continual care. The team was aware of the requirements of both the valproate and topiramate Pregnancy Prevention Programmes (PPPs). They had recently received supporting information to ensure they complied with the recently launched topiramate PPP.

Pharmacy team members used tubs and trays when dispensing medicines. This separated people's prescriptions from others to avoid items being mixed up. They signed the 'dispensed by' and 'checked by' boxes on medicine labels to provide an audit trail of their role within the dispensing process. They completed separate audit trails on prescription forms to identify which team member had completed specific tasks during the dispensing process. Team members generated a pharmacist information form (PIF) for each prescription dispensed. The PIF highlighted key information to support the clinical check

of prescriptions and the accuracy check of medicines. But not all PIFs accompanied the prescription and assembled medicine up until the point of handout. The RP explained that it was common for PIFs containing no relevant information to be discarded following the accuracy check of a medicine. A discussion highlighted the risk that this may lead to team members handing out assembled medicines making assumptions that there was no relevant information if a PIF had unintentionally become detached from a prescription form. The pharmacy retained prescriptions for the medicines it could not immediately supply to people, known as owings. Its 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.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner with most medicines held in the manufacturer's original packaging. An amber bottle containing some tablets with a handwritten label was not marked with the expiry date or batch number of the medicine inside the bottle. This was immediately removed by the RP and separated for safe disposal. The team recorded regular checks of the medicines it held to ensure they remained safe to supply. A random check of dispensary stock found no out-of-date medicines. Team members marked liquid medicines with details of their opening dates to ensure they remained fit to supply. The pharmacy stored CDs in a secure cabinet and medicines inside the cabinet were stored in an orderly fashion. Patient-returned and out-of-date CDs awaiting secure disposal were appropriately labelled and segregated from stock medicines. The pharmacy held medicines requiring cold storage in a medical fridge. It maintained records of the operational temperature range of the fridge and these records showed the fridge was working within the required temperature range of two and eight degrees Celsius.

The pharmacy had appropriate medicine waste receptacles to support it in disposing of patient-returned and out-of-date medicines safely. It encouraged people to return their unused inhalers to the pharmacy for recycling and it encouraged people using plastic injectable devices such as pre-filled insulin pens to recycle their pens through a manufacturer's pen recycling scheme. The pharmacy received medicine alerts and drug recalls electronically and team members checked for alerts frequently. The team monitored the frequency of the checks it made of these alerts and records showed the team was up to date with the actions required for all pharmacy alerts it had received.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the facilities and equipment it needs for providing its services. And it makes regular checks to ensure its equipment remains in safe working order. 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 resources via an online subscription service. They had access to the internet and a professional support telephone service. Team members used passwords and NHS smart cards to access people's medication records. The pharmacy's telephone handset was located in an enclosed part of the dispensary, out of ear shot of the prescription and medicine counter. Team members also had the option to use a cordless telephone to support them in protecting people's confidentiality when speaking to them over the telephone. The pharmacy protected personal identifiable information on bags of assembled medicines from unauthorised view.

The pharmacy team used a range of equipment to support it in delivering the pharmacy's services. This included standardised equipment for counting and measuring medicines. And equipment to support pharmacists in delivering consultation services such as blood pressure monitors, an otoscope with single-use earpieces and single-use tongue depressors. Equipment was from reputable manufacturers and checked periodically to ensure it remained safe to use. For example, the pharmacy's ambulatory blood pressure monitors were annotated with information to confirm they had recently been calibrated. The pharmacy's electrical equipment was annotated to show it was regularly checked to ensure it was in safe working order.

## 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. |