General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit L, Cleveland Retail Park, Skippers Lane Industrial Estate, MIDDLESBROUGH, Cleveland, TS6 6UX

Pharmacy reference: 1103527

Type of pharmacy: Community

Date of inspection: 10/07/2023

Pharmacy context

This community pharmacy is within a larger Boots store on a retail park in Middlesbrough. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy supplies a small number of 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

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	1.8	Good practice	The pharmacy clearly advertises its consultation room as a safe space for people to use. Its team members confidently act on concerns they have about a person's wellbeing. And the pharmacy supports them when they raise these concerns.
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 associated with its services. It keeps people's confidential information safe. And it responds to feedback it receives about its services appropriately. The pharmacy mostly keeps the records it must by law. Its team members have a good understanding of how to act to protect the wellbeing of vulnerable people. And the pharmacy supports them to act on safeguarding concerns to help keep people safe. They engage in shared learning following mistakes they make during the dispensing process to reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had a comprehensive range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. It held most of these electronically, some SOPs waiting to be updated in an electronic format were available in a folder within the dispensary. Training records indicated team members had completed relevant learning related to the SOPs. Learning for SOPs held electronically included the completion of an assessment to evaluate their understanding of the SOP. Pharmacy team members were observed completing tasks in the dispensary and at the medicine counter in accordance with SOPs.

Pharmacy team members mostly recorded mistakes made and identified during the dispensing process, known as near misses. They received feedback following a near miss and entered details of the event into an electronic record. Team members felt they recorded most near misses and recording rates were monitored through monthly patient safety reviews. These reviews also identified trends in mistakes and provided details of the actions the team was taking to reduce risk. For example, scanning the barcodes of medicines allowed the patient medication record (PMR) system to confirm the team member had selected the correct medicine. Following a mistake, the team emphasised the importance of a second team member checking the selection of medicines when the PMR system did not recognise a barcode. And team members also highlighted to the responsible pharmacist (RP) to prompt additional care. The RP explained how they would respond to a mistake that was identified following the supply of a medicine to a person, known as a dispensing error. This included speaking to the person affected, correcting the mistake, and reporting the incident. The team reported these types of mistakes to support an investigation. And it discussed learnings from the investigation to help inform risk reduction actions to prevent a similar incident occurring.

The pharmacy advertised how people could provide feedback and raise a concern. Pharmacy team members understood how to manage feedback and provided examples of how they responded queries and concerns. Team members engaged in mandatory learning relating to confidentiality and data security. The pharmacy held all personal identifiable information in the staff-only area of the premises and confidential waste was segregated and securely disposed of. The team engaged in safeguarding learning to help protect vulnerable people. They had the knowledge and experience to raise safeguarding concerns and were confident in doing this. A team member had received support from the company following them raising a concern. The pharmacy advertised its consultation room as a safe space for people to use. And team members knew to offer this safe space to people using code words associated with safety initiatives designed to offer a safe space to people experiencing domestic violence.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. A sample of pharmacy records examined mostly complied with legal requirements. But the address of the wholesaler was not always recorded in the controlled drug (CD) register when receipt of a CD was entered. The pharmacy maintained running balances in the CD register and completed full balance checks of physical stock against the register balance weekly. A random physical balance check of a CD carried out during the inspection complied with the running balance 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 has a small, dedicated team of people who work well together to provide its services. Team members complete relevant training, and the pharmacy supports them through structured learning and development reviews. Pharmacy team members engage in regular conversations designed to encourage safe working practices. And they are confident in providing feedback at work.

Inspector's evidence

The RP was a locum pharmacist who was familiar with the pharmacy. They were working alongside two pharmacy advisors (qualified dispensers) and the store's assistant manager. Another dispenser was due to leave the pharmacy soon, and their post had been recruited to and the new team member had commenced their role. The store manager was also a qualified dispenser and supported the team when required. The pharmacy did not have a regular pharmacist, but it did receive some consistent cover several days a week from a company-employed relief pharmacist. And the vacancy for a regular pharmacist had been filled subject to a foundation trainee pharmacist passing their GPhC registration assessment.

The assistant store manager was a pre-registration pharmacy technician. They had very recently moved to the pharmacy and team members were complimentary about the shared learning and improvements that they had supported with since joining the team. Team members completed regular learning associated with their roles, and training records were available for inspection. They engaged in a formal appraisal process to support their ongoing learning and development needs. And they understood how to provide feedback and raise concerns at work. A team member took the opportunity to discuss historic feedback they had provided. The pharmacy had a whistleblowing policy to support staff in raising concerns anonymously. And it advertised the details of a confidential employee assistance programme. Pharmacy team members were observed working well together and the RP took the opportunity to provide positive feedback about the team and the working environment. The pharmacy had some targets to support the delivery of pharmacy services. The RP on duty was not asked to meet specific targets and the assistant manager had a positive attitude that supported the safe delivery of the pharmacy's services. The team held regular short briefings to support continual communication. These briefings included formal patient safety reviews, training, and workload updates.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was secure and appropriately maintained. Team members knew how to report maintenance concerns and there were no current concerns. Heating and ventilation were controlled at store level and 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 staff area of the store.

The pharmacy area consisted of the medicine counter, dispensary, and consultation room. There was enough space in the dispensary to support current workload. The pharmacy's consultation room was clean and tidy. And it was fully accessible to people wishing to have a private word with a team member. The pharmacy used some space within the store's stock room to hold archived records and some dispensary sundries such as bags, bottles, and spare medicine waste receptacles.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. Pharmacy team members regularly engage people in conversations about their health and their medicines. And they support people in making informed decisions about their health. The pharmacy obtains its medicines from reputable sources. It generally stores its medicines safely and securely. And it makes regular checks to ensure they remain safe to supply to people.

Inspector's evidence

People accessed the store through automatic doors leading from the onsite carpark. The pharmacy was located on the back wall and was clearly visible from the entrance. There was a health promotion and seating area next to the pharmacy's consultation room. The current topic on the health promotion board provided information about common childhood illnesses. Pharmacy team members were aware of how to signpost a person to another pharmacy or healthcare service should the pharmacy not be able to supply a medicine or provide a service.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were confident in providing information to people. For example, they used appropriate questioning techniques to identify that a P Medicine was being requested for an indication which was not covered by the product license. They were observed explaining clearly why they were unable to sell the medicine. And they were observed referring queries to the RP when needed who took the time to speak to people. The RP provided several recent examples of counselling which had allowed people to make an informed decision about their health. Pharmacy team members had an appropriate awareness of how to manage requests for higher-risk P medicines subject to abuse, misuse and overuse.

The pharmacy team used tubs throughout the dispensing process to help ensure medicines stayed with the correct prescription. All prescriptions were observed to be accompanied by a pharmacist information form (PIF). The PIF contained relevant information about the medicines prescribed. For example, it highlighted changes in doses and new medicines. It was kept with prescription forms to inform safety checks throughout the dispensing process. The pharmacy had effective systems for managing the supply of medicines. For example, audit trails supported the team members in answering queries related to the home delivery service and the team took people's telephone numbers so a text message could be sent when a medicine was ready for collection. An audit grid on prescription forms identified who had completed tasks associated with labelling, assembling, clinical checks, accuracy checks and handing out. Pharmacy team members also signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail.

The pharmacy team used coloured laminated cards and prompts on the PMR system during the dispensing process to highlight higher-risk medicines. The cards accompanied the prescription up until the medicine was handed out to a person. They prompted additional monitoring checks and counselling requirements of these medicines. And the team recorded the outcomes of these conversations on people's PMR. It held assembled CDs and cold-chain medicines in clear bags. Bags containing CDs were annotated with details of the prescription's validity period. A discussion confirmed the team understood the requirements associated with the valproate Pregnancy Prevention Programme. And

team members had completed specific learning associated with the programme.

The pharmacy dispensed a small number of medicines in multi-compartment compliance packs. It completed an assessment of people's needs prior to commencing the supply of medicines in this way. Individual records associated with this service included clear details of people's medicine regimens. The team documented changes to people's medicine regimens clearly on a duplicate notebook designed for this purpose. But it did not detach the top copy of this record and transfer it to the person's individual record. A discussion highlighted the instructions on the notebook which clearly indicated the top copy of the record needed to transfer to people's individual record. And the team confirmed it would review its process to ensure the record was being used in the intended way. The pharmacy had no assembled packs waiting to be collected or delivered on the day of inspection. A team member discussed how the compliance packs were assembled. This included providing a dispensing audit trail and descriptions of the medicines inside the compliance pack. And the supply of patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy obtained its medicines from licensed wholesalers and generally stored them tidily. A couple of medicines were found in labelled amber bottles without details of the batch numbers and expiry dates available. This was discussed with the team and the medicines were disposed of. The team recorded activities associated with date checking. And it highlighted short-dated medicines with stickers. A random check of dispensary stock found no out-of-date medicines. Medicines with shortened-shelf lives once opened were annotated with details of their opening date to help ensure they remained safe to supply. The pharmacy kept its CDs securely, date-expired CDs and CDs people had returned were appropriately separated. The pharmacy's fridge was a suitable size for the medicines it held. Team members explained a second fridge was brought in to support vaccination services during winter months. The fridge temperature record showed the temperature had stayed within the appropriate range. The pharmacy had appropriate medical waste bins and CD denaturing kits to support the safe disposal of medicine waste. It received medicine alerts electronically and it kept an audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the required equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately.

Inspector's evidence

Pharmacy team members had access to a wide range of electronic reference resources through a subscription service. They 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 generally stored bags of assembled medicines in designated drawers within the dispensary. It held larger bags of assembled medicines in totes to the side of these drawers. A discussion highlighted the need to ensure information on bag labels and prescription forms within these totes faced away from medicine counter to mitigate any potential risk of accidentally sharing personal identifiable information. The team acted immediately to ensure this was done. Pharmacy team members used a cordless telephone handset when speaking to people over the telephone. 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. 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.