General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 16 & 17, St Stephens Shopping Centre, 110 Ferensway, Hull, East Riding of Yorkshire, HU2 8LN

Pharmacy reference: 9011161

Type of pharmacy: Community

Date of inspection: 17/05/2022

Pharmacy context

This community pharmacy is in a large shopping centre close to Hull city centre. The pharmacy provides a range of services including dispensing NHS prescriptions and private services such as chickenpox vaccinations. The pharmacy supplies medicines to people living in several care homes in the area. The inspection was in response to concerns raised by several care homes regarding delays to the supply of medicines. The pharmacy was inspected during the COVID-19 pandemic.

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	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 generally identifies and manages the risks associated with providing pharmacy services well. The pharmacy suitably protects people's private information. And it keeps the records it needs to by law. The team members respond correctly when errors happen. They regularly review the errors made and they use this information to take appropriate action to help prevent similar mistakes happening again. People using the pharmacy can raise concerns which the team suitably responds to. The team members have training and guidance to adequately respond to safeguarding concerns.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The team wore Personal Protective Equipment (PPE) face masks and the pharmacy had plastic screens on the pharmacy counter to protect the team. The pharmacy displayed COVID information notices. And the floor of the pharmacy was marked to show people where to stand to provide a level of social distancing.

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. The SOPs provided the team with information to perform tasks supporting the delivery of services. The team members accessed the SOPs and answered a few questions to confirm they had read and understood the SOPs. The team liked this format of the SOPs as they were easier to follow. Several SOPs were accompanied with videos explaining the procedure which helped the team members with their understanding. The manager received alerts about new SOPs or changes and monitored each team member's progress with reading and signing off the SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure to record and learn from errors made during the dispensing process known as near misses. The pharmacist when spotting an error discussed it with the team member involved and asked them to reflect on why it had happened. The team usually captured the error on an electronic record. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error happening again. The pharmacy completed electronic records of errors that reached the person known as dispensing incidents and sent them to the head office team.

The pharmacy undertook monthly reviews of the near miss errors and dispensing incidents. The trainee pharmacy technician completed the review and shared the results with team members in a meeting where they discussed the changes they could make to prevent future errors. And by attaching a summary of the recent review in the dispensary for the team to refer to. The trainee pharmacy technician used a review meeting to remind team members to always record their errors as he'd noticed a decrease in the number recorded. And had found in recent weeks the number of near miss errors recorded had increased. The pharmacy had labels attached to the shelves holding stock to prompt the team to check the medicine selected to help reduce picking errors. The pharmacist had altered the process for supplying people with supervised doses of their medicines to prompt the pharmacist to check the person's details and their expected dose before handing over. This helped to reduce the risk of someone receiving another person's medication. The care home team had investigated and altered its procedures after the wrong strength of medication had been supplied.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And it had information for people to know how to give feedback to the pharmacy team. The pharmacy provided the teams at the care homes with information on how to raise a concern. And the pharmacy team providing the service reinforced this message when contacting the care homes. The team had responded to concerns raised by some care homes regarding delays with the supply of medicines. And had reviewed the procedures to appropriately advise the care homes of any issues with the supply of medication. The team members had worked together to ensure the timely dispensing of prescriptions.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacists regularly checked CD stock against the balance in the register to spot errors such as missed entries. The pharmacy recorded CDs returned by people. The pharmacy had a leaflet informing people about the confidential data it kept. And it displayed a notice about the fair processing of data. The team members regularly completed training about the General Data Protection Regulations (GDPR). And they separated confidential waste for shredding offsite. The team clearly labelled the bins holding confidential waste to ensure it was not placed in the general waste bin.

The pharmacy had safeguarding procedures in place and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. The pharmacy provided a safe place for people to use and advertised this through a poster. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And team members completed internal Safeguarding training. The team was aware of the issues that would trigger a safeguarding referral but hadn’t had the occasion to refer anyone.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills needed to support its services. Team members work well together and are good at supporting each other in their day-to-day work especially at times of increased workload. They take opportunities to enrol on to training courses and are encouraged to take on additional responsibilities. The team members receive some level of informal feedback on their performance so they can develop their skills and knowledge.

Inspector's evidence

The pharmacy had one team supporting the pharmacy services from the main retail area. And a separate team providing the care home service in an upstairs room. A full-time pharmacist worked mostly in the main pharmacy but provided support to the care home team when required. The pharmacy employed regular locum pharmacists which meant there was usually two pharmacists on duty. When there was only one pharmacist both teams managed the workload to ensure tasks such as clinical checks were done. The main pharmacy team consisted of a full-time trainee pharmacy technician, a full-time dispenser and a full-time trainee dispenser. The store manager who had been in post three months was a trained dispenser and regularly provided support to the team. The team members in the main dispensary had experienced a reduction in team numbers which resulted in them being behind with some tasks such as date checking. The store manager had worked with the team on how to address this and the team members had offered to work extra hours to get ahead.

The pharmacy care home team consisted of a manager and a care home partner (CHP). Both were experienced dispensers who had been managers at several stores in the company. The manager had spent time with the team at another Boots pharmacy that supplied medicines to several care homes to see how the workload was managed. The rest of the team consisted of a part-time accuracy checking technician (ACT), four full-time dispensers and one full-time trainee dispenser. The team supported the trainee dispenser who was only tasked with additional responsibilities when they felt comfortable to do so. The care home team had consisted of two other ACTs and a regular pharmacist but they had left a few months earlier. The pharmacy was in the process of recruiting an ACT. But the team reported some increased workload pressure from the reduced team numbers which had led to a backlog of prescriptions requiring processing. All the team members had worked together to get ahead and several team members had worked longer shifts. The team had received support from the area manager and teams from other Boots pharmacies when required.

The team members used company online training modules to keep their knowledge up to date. And they had some protected time to complete the training. The pharmacy gave informal feedback to the team and was planning to reintroduce formal performance reviews to give team members a chance to receive individual feedback and discuss their development needs. The trainee pharmacy technician was keen to develop their skills and had taken on additional roles such as the monthly patient safety review. The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, one team member had suggested listing common errors at each workstation to alert team members to them, which had been implemented.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has good facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were hygienic and tidy. The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock, assembled medicines and medical devices and the team generally kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy was secure and it had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room which the team used for private conversations with people. The room was well equipped to support the range of services provided. And it contained a sink and hand sanitiser. The pharmacy had a separate area to enable people collecting their supervised doses of medication to do so in private.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services that support people's health needs and are easily accessible. The pharmacy generally takes appropriate action to ensure the delivery of its services remain safe and suitable. And it generally manages its services well to help people receive appropriate care. The pharmacy keeps detailed records to help monitor the services it provides particularly the supply of medicines to care homes. This enables the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out appropriate checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via the main store entrance. The pharmacy provided the Community Pharmacist Consultation Service (CPCS) which was popular due to the pharmacy's opening hours. Most of the referrals were appropriate but the RP reported occasionally a person presented who didn't meet the criteria and had to be referred back. The pharmacy provided its private services against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to supply a medicine or administer a vaccine. The team had paused the introduction of new services whilst there were reduced team numbers to allow everyone to get ahead with their workload. The team asked people appropriate questions when selling over-the-counter products and provided them with clear advice on how to use the medication.

The pharmacy supplied medicines to 49 care homes of varying sizes. The pharmacy had a dedicated team providing this service from a room separate to the main dispensary. To manage the workload the team divided the processing of the prescriptions across the month. And usually started the process two weeks before the start of the care home's next cycle. Each team member had a dedicated task to complete. This included checking the prescriptions received against the list of medicines ordered by the care home team to identify missing items or changes. These were recorded and sent to the CPH to raise as a query with the care home. Another team member generated the medicines administration record (MAR) and ordered the stock for the prescription. One of the team was responsible for dispensing acute prescriptions such as antibiotics and palliative care medicines along with medicines that started mid-cycle. However, they occasionally had to dispense monthly items for a care home that had not provided all the prescriptions on time. The pharmacy mostly supplied the medication a few days before the start of the next cycle to give the care home team time to check the supply. The team usually sent a form with the supply advising the care home team of any missing items. The pharmacy had a communications book that captured details of the conversations with the care home teams so all the team members knew what had been discussed if queries arose.

Most days a pharmacist and the part-time ACT checked the prescriptions, which varied in volume according to the size of the care home. On some days there was only the ACT checking the prescriptions. The pharmacy had previously had three ACTs who worked well together to ensure checking was complete and communicated with each other any issues. The ACT spoke to other team members on return to work to ensure she was up to date with any relevant information. The team placed prescriptions ready for collection in a separate room divided into sections for each care home. This ensured the delivery drivers only collected medicines that had been checked. The pharmacy had a cut-off time for deliveries to ensure the drivers could complete their deliveries. The CPH had a good

working relationship with the manager at the delivery driver depot and could arrange additional collections during the day when urgently required.

One the key roles in the team was the CPH who was the main contact for all the care homes and who the pharmacy team used when queries arose. The CPH had changed the email address provided to care homes from an individual one to a generic email address to ensure the emails were read in her absence. The CPH regularly monitored the emails throughout the day. And had a system to ensure all emails needing a response or action were completed by the end of the day. The pharmacy also had a dedicated phone line for the care homes teams. This was separate to an outgoing line which the team members had asked for to enable them to make calls when the other line was busy. The team had updated the information provided to the care homes teams on the processes they should follow and the timescales for the processing of prescriptions. The information also included the contact details of the team members the care home should raise any errors or concerns with. The pharmacy kept the list of medicines requested by the care homes and the completed missing items forms in case queries arose after the supply of medicines was made.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacy had limited the number of people it provided the service to whilst the teams adjusted to the workload pressures of reduced team numbers. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in a dedicated CD cabinet with the prescription.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had recently upgraded the computer system resulting in a change to the dispensing procedure. This included the team scanning the bar code on the dispensed product to see if it matched the prescription. The team noticed since the introduction of this process the number of picking errors had reduced. The team attached any information about the prescription or person obtained from the patient mediation record (PMR) for the pharmacist and ACT to refer to. The team used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person and to provide advice. The pharmacists recorded any relevant information from the person on to the PMR. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and they ensured people were provided with the relevant information. The pharmacy didn't have anyone prescribed valproate who met the criteria.

The pharmacy had checked by and dispensed by boxes on its dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample examined found that the team completed the boxes. The pharmacy used clear bags to hold dispensed CDs and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. And had a separate record for the supply to the care homes.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. And they kept a record of medicines due to expire each month so they could be removed from the shelf. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge

temperatures each day and a sample of these records were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned CDs separate from in-date stock in CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA). The team usually printed off the alert, actioned it and kept a record. The pharmacy displayed relevant MHRA alerts for all the team to see.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to correctly protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided. The equipment included a range of CE equipment to accurately measure liquid medication and the team used separate, marked measures for certain medicines.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.