General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Units 7 & 8, Riverside Retail Park, Smith St, Rochdale, Greater Manchester, OL16 1BE

Pharmacy reference: 9011350

Type of pharmacy: Community

Date of inspection: 20/04/2022

Pharmacy context

This pharmacy is located at the rear of a Boots store in a retail park in the town centre. The pharmacy dispenses NHS prescriptions and it sells a range of over-the-counter medicines. It supplies a large number of care homes and it dispenses some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. It offers a range of private services such as a travel clinic offering vaccinations and antimalarials and it dispenses private prescriptions from the Boots online prescribing service. The inspection was carried out 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	1.2	Good practice	The pharmacy employs a range of review and monitoring mechanisms for the services it provides to help it identify and manage any risks. And the pharmacy team records and analyses adverse dispensing incidents to identify learning points which it incorporates into day-to-day practice to help manage future risks.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their role, and there is a structured approach to training and development.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
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 manages the risks associated with its services to ensure it keeps people safe. It asks its customers for their views and the team generally completes all the records that it needs to by law. Members of the pharmacy team work to professional standards and they are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and act to help stop the same sort of mistakes from happening again. The team members complete training so they know how to protect children and vulnerable adults. The pharmacy has written procedures on keeping people's private information safe, but the design of the dispensary could be improved to prevent people's confidential information being seen.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided and records were available showing members of the team had read and accepted them. SOPs were available in different formats including digital versions. The store manager alerted staff when there were new or amended SOPs to read. Roles and responsibilities were set out in the SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Dispensing incidents and near misses were recorded, reviewed and appropriately managed via regular patient safety reviews. Near miss incident logs were used to note down incidents as they occurred, and there was a separate log used in the care home room. Look-alike and sound-alike drugs 'LASAs' were highlighted. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. There were regional patient safety meetings where people from around 20 branches met and discussed incidents and shared learning. The patient safety champion in the pharmacy cascaded learning from this meeting to the rest of the team. There was a new patient medication record (PMR) system which included a safety feature whereby the bar codes on medicines were scanned, and if the incorrect medicine or strength had been selected, the dispenser would be alerted . One of the dispensers explained that the team were currently concentrating on quantity errors as this was the main form of error since the introduction of the new PMR system. If the medicine did not have a bar code 'NB' would be added to the prescription so the pharmacist would know to be extra vigilant and carry out an extra check on the accuracy, as the dispenser had not been able to scan the medicine to verify it. A 'Professional Standards Bulletin' was received from head office every couple of months which staff read and signed. It included case studies with points for reflection and a root cause analysis. It also highlighted risks which had been identified and suggested ways to minimise these.

The store manager had considered the risks of coronavirus to the pharmacy team and people using the pharmacy and had introduced several steps to ensure social distancing and infection control. All members of the team were wearing face masks. There were notices displayed in the consultation room explaining the symptoms and treatment of fainting, seizures and anaphylaxis and the process to follow after a needle-stick injury or accidental exposure to blood. This helped the team to manage the risks associated with the vaccination service. Audits were carried out regularly including clinical audits such

as recent one on non-steroidal anti-inflammatory drugs (NSAIDs).

‘Tell us how we did cards’ were available for people to provide feedback on their experience in the pharmacy. The store manager received this feedback and highlighted any relevant issues to the pharmacy team. Care homes provided feedback to the Boots care home pharmacist who carried out regular visits there. This feedback was displayed on the team’s notice board outside the care home room.

Professional indemnity insurance was in place. There was an electronic private prescription register. Private prescriptions generated by an online prescriber, as part of the travel clinic, had not been recorded in the register, which meant the record was incomplete and this could cause confusion in case of a query or problem. The RP record and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately. A pharmacist’s log was completed daily and weekly by the RP. The fridge temperature, RP notice, CD key security and records were checked as part of this.

Pharmacy team members had completed online training on information governance (IG), including confidentiality and data protection. Confidential waste was collected in designated bags which were sealed and sent to head office for destruction. A dispenser correctly described the difference between confidential and general waste. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). The dispensary was open plan and dispensing took place in close proximity to the retail area. People standing in front of the dispensary could potentially see prescriptions that were being assembled which risked breaching patient confidentiality. The store manager confirmed that the team was aware of this issue and tried to manage the risk by asking people to stand away whilst waiting for their prescription. The pharmacy sent people’s prescriptions to a third-party registered dispensing appliance contractor for them to dispense, without obtaining explicit consent from the person, which was a potential breach of their confidentiality.

Pharmacy team members had completed training on safeguarding. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a safeguarding notice on display containing the contact numbers of who to report concerns to in the local area. There was a notice on display highlighting that the consultation room could be used as a ‘safe space’ where victims of domestic abuse could contact specialist services for support and advice.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members are well trained and they work effectively together. The pharmacy encourages them to keep their skills up to date and supports their development. They are enthusiastic and knowledgeable. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance. The pharmacy has enough team members to manage its workload safely. It enables the team members to use their professional judgement to benefit people who use the pharmacy's services.

Inspector's evidence

The RP was the regular pharmacist. There were four NVQ2 (or equivalent) qualified dispensers and a trainee dispenser on duty. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the people who visited the pharmacy. The store manager was also a qualified dispenser and supported the pharmacy team when necessary. She organised the resource planner to ensure adequate staffing levels and skill mix. Staff absences were covered by re-arranging the planner and there was an option of transferring staff from neighbouring branches if necessary. There was usually one pharmacist on duty to cover both the main pharmacy and the care home room. But two days each month, when the workload in the care home room was heaviest, there was an additional pharmacist.

The staff used an online learning system to ensure their training was up to date and undertook assessments to check learning. Mandatory training was completed such as health and safety, fire and manual handling, and the team were also able to access a wide range of professional training resources. Staff carrying out the services had completed appropriate training and appeared confident and competent. They explained they were generally given regular protected training time, but when this was cancelled due to workload pressures, they completed the required training in their own time at home.

Pharmacy team members were given formal reviews where performance and development were discussed and received feedback informally from the store manager or regular pharmacist. Informal staff meetings were held regularly where a variety of issues were discussed, and concerns could be raised. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to her manager or the pharmacist about any concerns she might have. She said the staff worked well as a team and could make suggestions or criticisms informally. The dispenser felt comfortable reporting errors and felt that learning from mistakes was encouraged. There was a whistleblowing policy.

Pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to supply a prescription if they felt it was inappropriate. Targets were in place for some of the services, and these were closely monitored, but the RP confirmed that she didn't feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to receive services in private and have confidential conversations.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean, spacious, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with five chairs. The temperature and lighting were adequately controlled. The pharmacy had relocated into the new premises a couple of years ago and was fitted out to a good standard. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue.

There was a separate room on the first floor for care home assembly and community compliance aids. It was fitted with a digital lock and a dispenser confirmed it was usually locked when nobody was working there to prevent unauthorised access. It was on one side of a large stockroom. Staff facilities were also on the first floor and included a staff room with a kitchen area, WCs and wash hand basins. There was a separate dispensary sink in the care home room and in the ground floor dispensary for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

There was a consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services such as vaccinations, and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. Services are generally well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was accessible to all, including people with mobility difficulties and wheelchair users and there was a hearing loop in the pharmacy. There were some leaflets advertising services, such as the travel clinic but there wasn't a full list of all the services provided on display. This information was available on the NHS.UK website. There was a health zone and a variety of healthcare leaflets were available. Some local services were advertised such as the Rochdale carers hub, as well as national support services and charities such as MIND.

Space was adequate in the dispensary, and the workflow was organised into separate areas. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. A quad stamp was completed on the prescription showing who had dispensed, clinically checked, accuracy checked and handed out the prescription. Tubs were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. Pharmacist's information forms (PIFs) and laminated 'Care' labels were used to highlight that a fridge line, CD or new medicine had been prescribed or if any other counselling was required. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out a couple of years ago and people in the at-risk group had been identified and counselled. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. A trainee dispenser explained what questions she asked when making a medicine sale and knew when to refer the person to a pharmacist. She was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

The pharmacy provided multi-compartment compliance aid packs for some people who lived independently in the community. The service was well organised with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed. Medicine descriptions were included on the labels to enable identification of the individual medicines. Packaging leaflets were included so people were able to easily access additional information about their medicines. Disposable equipment was used to prevent contamination. There was a SOP for new people requesting a compliance aid pack. An assessment was made by the pharmacist as to the appropriateness of a pack or if other adjustments might be more appropriate to their needs. The pharmacy also supplied a large number of care homes. These medicines were supplied in original packs. Medicine administration records (MAR) charts were provided with the medicines. When prescriptions were received, they were matched to the request made by the care home and any discrepancies chased up. There was a log made of missing items and queries, and a care home communication book was used to record any messages. Specific care service PIFs were completed for every patient to ensure all the relevant

information was available for the pharmacist when carrying out their clinical and accuracy check.

The pharmacy used a combination of patient group directions (PGDs) and private prescriptions for their private services. The pharmacist carrying out a consultation as part of the travel clinic would enter all the patient's details and travel arrangements onto the computer and a private prescription was generated for diphtheria, tetanus, polio, hepatitis A & B, typhoid, tick-born encephalitis, rabies, Japanese encephalitis and cholera vaccines. The prescription contained the GPhC number and signature of a pharmacist independent prescriber but the prescription appeared to be 'autogenerated' without any apparent review of the individual questionnaire by the prescriber, which might increase risk. The vaccines were not labelled so the prescription was not recorded in the private prescription register, which is not strictly in line with legislation. There was a SOP for this process and the RP confirmed she would review this practice in line with the SOP. People receiving private services were given a consultation summary but the onus was on the patient to inform their GP, so there was a risk that this information was not shared with their own GP and their medication records would not be updated.

The pharmacy dispensed prescriptions from the Boots online private prescription service. This was treated as a fulfilment service by the pharmacy team. No checks were made at the point of collection that the patient had entered the correct details on the online questionnaire. And the pharmacy team did not know if there was a protocol on how they could query or reject a prescription from this service if they had a concern or required more details. However, the RP stated that she would refuse to supply a prescription for a weight loss medicine such as Saxenda, if the person collecting it was clearly underweight, and she said she would contact head office to find out how to speak to the prescriber in this scenario.

CDs were stored in two CD cabinets which were securely fixed to the floor. The keys were under the control of the RP during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins. Alerts and recalls were received from head office via messages on the intranet. These were read and acted on by the pharmacist or member of the pharmacy team and then filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available for reference, and the pharmacist could access the internet for the most up-to-date information. There were three clean medical fridges. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. Any problems with equipment were reported to head office or re-ordered. There was a selection of clean liquid measures with British Standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy also had a range of clean equipment for counting loose tablets and capsules. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.