General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 55 Middle Street South, DRIFFIELD, North Humberside, YO25 6PS

Pharmacy reference: 1032029

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

This community pharmacy is in the centre of the market town of Driffield. The pharmacy dispenses NHS and private prescriptions. And it provides medication in multi-compartmental compliance packs to help people take their medicines. The pharmacy provides supplies of emergency hormonal contraception. And it provides a needle exchange 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	Good practice	2.2	Good practice	The pharmacy provides all team members with opportunities to complete more training. And it plans team training in advance of the introduction of new systems. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career.
		2.4	Good practice	The pharmacy team has an open and honest culture. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. And they take opportunities from company surveys to provide feedback with an aim to improve service delivery.
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 identifies and manages the risks associated with its services. And it mostly keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has appropriate arrangements to protect people's private information. The pharmacy team members respond well when errors happen. They discuss what happened and they act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback which the team responds to. The team members have training, guidance and experience to respond well to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. And the procedures for the team to follow when using the recently introduced off-site dispensing support pharmacy (DSP). The team had read and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors. And the team member involved completed the record. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. And most team members recorded what caused the error, their learning from it and actions they had taken to prevent the error happening again. The team analysed the information captured on these reports and recorded the outcome. But some sections of the analysis record were incomplete. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team printed off the report for reference. A recent incident involved the wrong name on a dispensing label. The team identified the cause and recorded it. One team member had accessed the electronic patient record (PMR) to label the prescription. But when they moved away to pick a medicine from the shelf another team member used the PMR to look for a different person. The first team member didn't notice the change and carried on labelling. So, the wrong name was printed on the label. And this was not spotted at the final check of the prescription. The team discussed the error and agreed to always ask if the computer was free before using it. The team also agreed to not disturb colleagues who were dispensing and checking prescriptions.

The pharmacy undertook monthly and annual patient safety reviews. The accuracy checking technician (ACT) led on this and shared the results with the team. The ACT displayed the outcome from the latest review in the dispensary for the team to refer to. A recent review reminded the team to take extra care when accessing the PMR to help reduce errors. The pharmacy had labels that asked the team to select and speak the product selected. The team attached these labels to shelves holding items that looked and sounded alike (LASA). The team attached to each computer terminal a list of common LASA medicines. This acted as a prompt for the team to check the medicines selected from the PMR. The team managed the dispensing workload by providing people with the time taken to complete prescriptions. So, the person could decide to wait or come back.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it

had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. Pharmacy team members responded well when people made a complaint.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that on a few occasions the entries were not completed. But the pharmacists had completed the Boots pharmacist log on these dates. The pharmacy manager was aware of this and had raised it with the pharmacists. Most records of private prescription supplies met legal requirements. A sample of records of emergency supplies of medicines looked at met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). 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 separated confidential waste for shredding offsite.

The pharmacy team members had information on how to raise a safeguarding concern. And they had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training on 07 April 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The ACT had completed the same training on 25 July 2019. The team had completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And the team members are good at supporting each other in their day-to-day work. The pharmacy reviews team hours when it needs to and it acts to address any gaps. The pharmacy provides all team members with good opportunities to complete more training. And it plans team training well in advance of the introduction of new systems. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. The pharmacy team has an open and honest culture. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. The team members discuss how they can make improvements. And they take opportunities from company surveys to provide feedback with an aim to improve service delivery.

Inspector's evidence

Two branch pharmacists covered most of the opening hours. Boots relief pharmacists provided support when required. The two branch pharmacists had some overlap time during the week. The pharmacists used this time to catch up with checking prescriptions and providing services. The pharmacy team consisted of one full-time accuracy checking technician (ACT), one full-time level three national vocational qualification (NVQ3) trainee, one full-time qualified dispenser, who was also the pharmacy manager, one part-time dispenser, one part-time trainee dispenser and two part-time healthcare assistants (HCA). At the time of the inspection one of the branch pharmacists, the full-time pharmacy manager, the full-time NVQ3 trainee, the part-time trainee dispenser and the part-time HCA were on duty. The NVQ3 trainee supported the trainee dispenser. The pharmacy provided the trainees with protected time to complete their modules.

The pharmacy trained the team on key tasks such as managing the repeat prescription ordering service. This ensured the team members had a range of skills, so they could support the pharmacy services in times of absence. The pharmacy manager had spoken to the area manager about increasing the number of qualified dispenser hours. The pharmacy manager had been advised to use qualified dispensers from local branches. But the pharmacy manager recognised that qualified dispensers from other branches may not always be able to support the team. So, had discussed and encouraged the recently qualified HCA to enrol on to the dispenser training course. The HCA was keen to do the extra training and had agreed. This meant the team had extra dispenser hours without relying on external support.

The pharmacy provided extra training through e-learning modules. The team members had protected time to complete the training. The team read and signed the publication sent from the Boots Professional Standards team. The publication provided the team with information such as safe delivery of pharmacy services. And learning from dispensing errors. The pharmacy held daily and weekly team huddles. And once every few months the pharmacy manager arranged an evening meeting, so all the team could attend. The team used the huddles and meetings to plan work, share the outcomes from the patient safety reviews and discuss new company initiatives. The pharmacy manager also shared key points from the regional managers meetings. The pharmacy had a communications book for the team to share information with each other.

The pharmacy provided formal performance reviews for the team. And the pharmacy manager gave team members informal feedback. The pharmacy had a template for team members to record their observations about each other when they were providing pharmacy services. The template included the advice the team member had given to people using the pharmacy. And the feedback from the colleague observing. Examples included good advice given to a person who asked to buy a medicine to treat threadworms on how to prevent them. The team used all these opportunities of feedback to reflect on their roles and consider development needs. The NVQ3 trainee had taken the opportunity to discuss leadership roles.

Team members could suggest changes to processes or new ideas of working. The team had raised with the local GP surgeries the problems caused by not having electronic (EPS) prescriptions. And the impact this was having on the team. But the surgery teams continued to send paper prescriptions. The pharmacy was due a computer software upgrade. And it was asked to appoint one team member as a champion during the upgrade. So, the team members had someone who understood the changes. And to help them complete the training. All the dispensary team had expressed interest in being the champion. So, the pharmacy manager decided to name several team members as champions. The pharmacy manager arranged for the team to spend time with other teams using the new software. The pharmacist had attended a local pharmacy in her own time. The pharmacy manager arranged cover when the team members were at the other pharmacies. So, the delivery of services was not affected. The company asked pharmacy teams to provide feedback through staff surveys. The pharmacy manager used the latest survey to highlight the enthusiasm the team members had to provide more pharmacy services. And reported via the survey that the team could not develop the services due to limited team numbers and workload pressures. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The room was a little distance from the pharmacy counter. The pharmacy didn’t have a notice to inform people of the availability of the room. The pharmacy provided a screened area for people to take their methadone doses in private. And for people using the needle exchange service.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately. The pharmacy team members engage with people using the pharmacy services. And they respond to the needs of the local community. The pharmacy team responds well when a person reports unexpected side effects from their medicines.

Inspector's evidence

People accessed the pharmacy via two step-free entrances. One entrance had an automatic door. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy had a section promoting healthy living advice. The current focus was the use of antibiotics. The team wore name badges detailing their role.

The pharmacy made supplies of emergency hormonal contraception (EHC) against up-to-date patient group directions (PGDs). This gave the pharmacists the authority to supply the EHC medicine. The two branch pharmacists were trained and authorised to supply the EHC medicines. The EHC service was popular as no other pharmacy in the town provided the service. And teams from other pharmacies referred people to this pharmacy.

The pharmacy provided multi-compartmental compliance packs to help 16 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team members divided the preparation of the packs across the month. And they had a list of people receiving the packs. The team members marked the list when they completed each stage of preparing the packs. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And separated people’s doses to reduce the risk of selecting the wrong one. The pharmacists offered people prescribed methadone an annual medicine use review. So, they could discuss their treatment and any other concerns they had about drug use. The needle exchange service involved people placing the used needle containers into the appropriate bin. So, the team had no direct contact with the containers. The team reminded people to always return used needles in the appropriate bins. And to bring them back to the pharmacy. The team had focused on this following an article in the local paper highlighting issues with used needles being found in public areas. The team also provided people with information on how to safely use needles.

The team members provided a repeat prescription ordering service. The pharmacy had seen an increase in people requesting this service after another pharmacy introduced restrictions on who could use the service. The team members used an electronic system to remind them when they had to request the prescription. And they used this as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team checked the system to identify missing prescriptions and chase them up with the GP teams.

The pharmacy received most prescriptions in paper format. This was due to local GP surgeries not transferring to electronic prescriptions (EPS). The pharmacy sent several prescriptions to the Boots dispensing support pharmacy (DSP). Part of the procedure for sending the prescriptions to the DSP required the team to input the prescription details. EPS prescriptions would embed straight into the system on receipt at the pharmacy. But the team had to manually input the paper prescriptions. This took the team extra time as the barcode on the paper prescriptions did not always scan. Or sometimes the paper prescription did not have a barcode. The accuracy checking technician (ACT) checked the data entered. And the pharmacist completed a clinical check of the prescription before the pharmacy sent it to the DSP. The team placed prescriptions for the DSP in a labelled tub awaiting these checks. The DSP could not dispense medicines such as controlled drugs and dressings. The team members marked the prescription to show some of the medicines were for the DSP and some for the pharmacy team to dispense. So, they could ensure they supplied the person with all their medicines. The DSP usually returned the prescriptions two days after receiving the prescriptions. The DSP sent the medicines in sealed bags and indicated on the label attached to the bag any missing medicines. The team members placed these bags in a tub with a laminate card prompting them to dispense the missing medicine.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The pharmacy team used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person obtained from the electronic medication record (PMR) during labelling. These forms included dose changes or new medication. The team also used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person. For example, their latest blood test results. And the team recorded this information. The PIF stayed with the prescription until the team supplied the medication. So, everyone could refer to the information captured on the PIF. The team used the PIF to record medicines that looked and sounded alike (LASAs), as these were often linked to errors. The team members used this as a prompt to check what they had picked. For example, one PIF had 'prednisolone LASA' recorded. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had the PPP pack containing information to give to people. The team was also alert to other high-risk medicines such as isotretinoin.

The pharmacy used clear bags to hold dispensed controlled drugs (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. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a quad stamp. The pharmacy used this as an audit trail of who had clinically checked, accuracy checked, dispensed and handed out the medication. The pharmacy displayed a note in the dispensary reminding the team to complete the boxes. The note asked the team members to sign to show they had read and would follow the

instructions. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 17 September 2019. The team used a 'caution short dated stock' sticker with the expiry date written on to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members recorded the date of opening on liquids using a sticker that had the date of opening and the date the product should be used by. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of risperidone 1mg/ml oral solution with three months use once opened had a date of opening of 04 September 2019 recorded. And a used by date of 27 November 2019. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and returned medication. And it stored out of date and returned controlled drugs (CDs) separate from in date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures to meet the requirements of the Falsified Medicines Directive (FMD). And it was waiting for a computer upgrade to support FMD. The team hadn't received any training. But the pharmacy manager had recently discussed FMD at a team meeting to remind the team of the requirements of FMD. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record. The team responded well when informed by people of safety issues with their medicine.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and 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 used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. The team used one fridge for storing the completed prescriptions awaiting collection. The team stored the completed prescriptions in alphabetical order, so they were easy to find. The team used the other fridge for stock. The pharmacy completed safety checks on the electrical equipment.

The 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.