General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 27 Bridgegate, Howden, GOOLE, North Humberside, DN14 7AA

Pharmacy reference: 1032033

Type of pharmacy: Community

Date of inspection: 13/04/2023

Pharmacy context

The pharmacy is in the centre of Howden which is a large market town in East Yorkshire. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It supplies some people with their medicines in multi-compartment compliance packs to help them take their medication. And it delivers medicines to several people in their 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	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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it completes the records it needs to by law. Team members suitably protect people's confidential information, and they demonstrate a clear understanding of their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond correctly when errors happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) which provided team members with information to support the safe and effective delivery of its services. They accessed the SOPs via an online platform and answered a few questions to confirm they had read and understood them. The pharmacy manager was alerted to new SOPs and changes made to existing SOPs and ensured the team read the updated versions. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions, known as near miss errors. These included errors identified by team members before they reached the final accuracy check. A record of the near miss errors was kept. A paper record was initially used to capture the details before the information was transferred to an electronic platform. This ensured all near misses were captured at the time they occurred. A sample of near miss records found the details included the team member's thoughts on why the error had happened. The pharmacy completed electronic records of errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident and the actions taken to prevent a similar incident. The team had investigated a recent dispensing incident involving the wrong dose instructions on a dispensing label. This revealed that a check of the dosage instructions automatically copied from the electronic prescription was not followed. So, team members were reminded to always check the information from the prescription manually before generating the label.

A review of the near miss errors and dispensing incidents regularly took place and involved all the team. The outcome from the review was shared with team members who discussed the changes they could make to prevent future errors. Recent reviews identified that quantity errors were often linked with spilt packs and the team was reminded to ensure such packs were clearly marked. Changes to pack sizes were highlighted to team members for example when a pack that was usually a quantity of 28 tablets was changed to a pack of 56 tablets. The team member putting the stock away had noticed the change, highlighted it to the team and circled the quantity on the box to alert the team to the change. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A leaflet provided people with information on how to raise a concern with the pharmacy team. And people were invited to leave feedback through the company's online platform and team members explained the feedback was positive about the service they provided.

The pharmacy had current 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 correct RP notice was displayed. The pharmacy completed regular checks of the balance of the CD

registers against the physical quantity to identify errors or missed entries. And a record was kept of CDs returned by people for destruction. Team members had completed training on the General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacy displayed information on how confidential data was protected and it displayed a notice about the fair processing of data.

The pharmacy provided the team with safeguarding training and guidance. And the pharmacist and pharmacy technicians had completed up-to-date training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Team members responded well when a safeguarding concern arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a good range of experience and skills to help safely provide its services. Team members work very well together and are good at supporting each other in their day-to-day work. They benefit from identifying areas of their own practice they wish to develop. And the pharmacy supports them with ongoing training to advance their skills and knowledge.

Inspector's evidence

A part-time locum pharmacist and employed relief pharmacists worked at the pharmacy. The pharmacy team consisted of a full-time pharmacy manager who was a qualified dispenser and a full-time accuracy checking technician (ACT). There was also a full-time pharmacy technician, a part-time pharmacy technician, a full-time dispenser, a part-time dispenser and a part-time trainee dispenser. The pharmacy manager had been in post six months having previously worked as a dispenser in the pharmacy for several years. They received support from the area manager and managers from pharmacies in the area. The ACT had regular opportunities to check prescriptions to ensure they maintained their skills. And they could help colleagues with dispensing when required.

Team members worked very well together and supported each other. Team members had some specific roles such as the ACT preparing supervised doses of some people's medicines. However, all team members were trained on how to undertake key tasks. And a team rota ensured there was always one team member working at the pharmacy counter, so people were not kept waiting. Team members prepared for the potential impact on the team's workload such as weeks with a bank holiday and planned absences.

Team members used company online training modules to keep their knowledge up to date. And they had protected time at work to complete the training. They also completed CPPE training such as for risk management and sepsis. The team read the publication sent from the Professional Standards team that provided information about new services and learning from dispensing errors. Team members received formal and informal feedback on their performance, and they had opportunities to discuss their development needs. The ACT had used the opportunity to ask for additional responsibilities such as checking the CD balance, which was agreed. The team held regular meetings to plan the work for the day and to discuss other matters such as recent near miss errors.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. The team kept floor spaces clear to reduce the risk of trip hazards. And there was sufficient storage space for stock, assembled medicines and medical devices. The dispensary layout provided limited bench space for the team members to work from. They generally managed the space well but occasionally some tubs used in the dispensing process were piled on top of each other, creating an increased risk of errors.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. There was a soundproof consultation room for the team to have private conversations with people and when providing services such as flu vaccinations. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services well to make sure people receive their medicines when they need them. They store medicines properly and they regularly check to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door operated by a press pad. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. Team members provided people with information on how to access other healthcare services when required. And they wore name badges detailing their role so people using the pharmacy knew who they were speaking to. People were provided with clear advice on how to use their medicines and were asked appropriate questions when requesting over-the-counter products.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. The service was managed by the pharmacy technicians with support from other team members. Prescriptions were ordered several days before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which was regularly referred to during the dispensing and checking of the prescriptions. The packs were usually checked in a small room away from the distractions of the retail area and main dispensary. Descriptions of the medication within the packs were recorded and the manufacturer's packaging leaflets were supplied. This meant people could identify the medicines in the packs and had information about their medicines. A few people received their medicines daily as supervised and unsupervised doses. The doses were prepared in advance to reduce the workload pressure of dispensing at the time of supply. They were stored securely in date order with the prescription attached and in sections that separated people's doses. This helped to ensure the correct person's dose was selected. A final check of the pre-prepared dose was completed at the time the person presented. And the person was asked to confirm their details and the dose they were expecting.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. And team members used tubs to keep people's medicines with the correct prescription. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. And a sample found the team completed both boxes. There was also an audit trail on the prescription to capture who had downloaded the electronic prescription, completed the clinical and accuracy checks and handed out the medication. Team members used alert cards for higher-risk medicines to prompt the pharmacist to ask for information from the person such as their latest blood test results. So, they could assess whether the medicines were suitable to supply. The person's PMR was updated following such conversations so the team could refer to the records at a later date if required. Information identified during the dispensing process, such as a new medicine or a dose change was printed off with the dispensing label and kept with the prescription. This meant the pharmacist was aware and it prompted the team to discuss the information with the person when handing over their medication. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And they regularly reviewed people prescribed valproate to identify

anyone who may meet the PPP criteria.

The pharmacy used clear bags to hold dispensed fridge lines and CDs so the team, and the person collecting the medication, could check the supply. And it had a system to prompt the team members to check that supplies of CD prescriptions were within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. People received a text message from the pharmacy advising them when their prescription was ready to collect. The team stored completed prescriptions neatly in a dedicated area. And scanned the prescriptions into a particular location using a barcode attached to the location. When the person came to collect their prescription, the team used the barcode scanning to identify where the prescription was held and to check the correct prescription had been picked. A record of the delivery of medicines to people was kept for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources and the team members followed the pharmacy's procedures to ensure medicines were safe to supply. They monitored stock availability and contacted prescribers to discuss alternate products when required. They checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were marked to prompt the team members to check the medicine was still in date. And they kept a list of medicines due to expire each month. The dates of opening were recorded for medicines with altered shelf-lives after opening so 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 found they 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. Team members used appropriate denaturing kits to destroy CDs and promptly destroyed CDs returned by people. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Team members printed off the alert, actioned it and kept a record. Recent alerts relevant were displayed on the team's notice board so everyone was aware.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And a fridge for holding medicines requiring storage at this temperature. Safety checks on the electrical equipment regularly took place.

The pharmacy's computers were password protected and access to people's medication records were restricted by the NHS smart card system. Team members used cordless telephones to help ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other confidential information in the dispensary which had restricted public access.

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.