General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 10 - 11 Market Place, SELBY, North Yorkshire, YO8 4PB

Pharmacy reference: 1038995

Type of pharmacy: Community

Date of inspection: 16/02/2023

Pharmacy context

This community pharmacy is in the centre of Selby, which is a large market town in North Yorkshire. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some people with their medicines in multi-compartment compliance packs to help them taken their medication. And it delivers medication to several people in their homes. The pharmacy offers other services including the NHS hypertension case finding service.

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 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 appropriately 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 the team with information to perform tasks supporting the delivery of its services. Team members accessed the SOPs via an online platform and answered a few questions to confirm they had read and understood them. They received notification of new SOPs or when changes were made to existing SOPs, and they had protected time at work to read them. 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. The team member involved was asked to identify their error, correct it and record it on to an electronic platform. Team members recorded their own errors to support their learning and were reminded to complete the record at the time it occurred, so it wasn't missed. The pharmacy manager monitored this process and highlighted any missing entries with the team member involved. The pharmacy completed electronic records of errors identified after the person received their medicine, known as dispensing incidents. And the team recorded the incident on to the person's electronic patient medication record (PMR), so everyone was aware. All team members were informed of the dispensing incident and the actions taken to prevent a similar incident. Following a recent dispensing incident when the wrong strength of a medication was supplied the pharmacist shared their checking process with the team members. So, they could check the prescription they'd dispensed before passing it to the pharmacist.

The near miss errors and dispensing incidents were regularly reviewed by all the team members. And the outcome from the review was shared with team members who discussed the changes they could make to prevent future errors. As part of the dispensing process team members scanned the bar code on the dispensed product to see if it matched the prescription. But they had identified an increased risk of a selection error when dispensing medicines with no barcode on the packaging. So, they agreed to complete a second check on these prescriptions to reduce the risk. 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.

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 pharmacy completed regular checks of the balance of the CD registers to identify errors or missed entries. 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 had completed training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Team members were aware of the Ask for ANI (action needed immediately) initiative which helped people experiencing domestic abuse and they displayed posters in the retail area advising people that the pharmacy offered a safe space. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work very well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time employed Boots pharmacist covered most of the pharmacy's opening hours with locum pharmacist support when required. The team consisted of a full-time pharmacy manager who was an accuracy checking technician (ACT), a full-time pharmacy technician, two full-time dispensers, a part-time trainee dispenser and a part-time dispenser who worked as a medicines counter assistant. Team members worked very well together and supported each other particularly to ensure people who presented at the pharmacy counter were not kept waiting. All team members were trained on how to undertake key tasks and a rota ensured these tasks were completed each day. The rota also supported the team at times when team numbers were reduced such as for unplanned absence. The pharmacist had a system to ensure all tasks such as CD register entries were completed by the end of each day.

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 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. One of the dispensers had taken on the role of patient safety champion and supporting the trainee dispenser.

The team held regular meetings which were often triggered when important information had to be shared. And were also used to impart feedback from people who had used the pharmacy services, often from posts left on social media platforms. They also shared details such as medicines with similar packaging to alert everyone to the risk that the wrong product may be picked. Team members not on duty at the time were updated when they were next on duty. The team used an online forum to contact other teams when queries arose. Team members had identified that the popularity of the flu vaccination service often led to several people waiting near the pharmacy counter alongside people wanting other services. So, they set up a separate area for people to wait when presenting for the flu vaccination. This was close to the consultation room and had healthcare information available for people to read.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate 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. The team kept floor spaces clear to reduce the risk of trip hazards. And there was enough storage space for stock, assembled medicines and medical devices.

The main dispensary had limited workspace, so the team had converted a room previously used for developing photographs into an area for dispensing prescriptions for multi-compartment compliance packs. And for storing the completed packs. 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 door into the room was made of clear glass so a curtain was in place for the team to draw across when using the room. 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. And there was plenty of space for people to move around the retail area. 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 had several prescriptions dispensed by the company's offsite dispensary hub. The team processed the prescriptions, and the pharmacist completed a clinical check of the prescriptions before the prescription data was sent to the hub for dispensing. Some medicines such as CDs and items the person urgently needed like antibiotics were dispensed at the pharmacy to reduce risk. And to ensure the medicines were ready when people needed them. The dispensed prescriptions were generally returned to the pharmacy within 48 hours of the hub receiving the prescription data. They were supplied in a sealed bag with a label attached listing the person’s details and information such as missing medicines to be dispensed at the pharmacy. On several occasions the team had dispensed the missing items only to discover that the sealed bag had contained all the prescribed medication. So, in response the team opened any bags labelled that indicated missing items before dispensing the medication. And reported any discrepancies. The partially completed prescriptions were stored separately to prevent incomplete prescriptions being supplied to the person. The team generally used the dispensing hub from Monday to Thursday. On Fridays or close to a Bank Holiday the team dispensed the prescriptions at the pharmacy to reduce the risk of delays to the supply.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. Dispensary team members were responsible for dispensing a group of these prescriptions each. They used a room to the rear of the pharmacy away from the distractions of the main dispensary and retail area to dispense and check the packs. 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 team recorded the descriptions of the medication within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy supplied a few people’s 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. And were stored securely with the prescription in tubs labelled with the person’s name. This helped to ensure the correct person’s dose was selected.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team

used baskets 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. The pharmacy also used a stamp to capture who had downloaded the electronic prescription, who had completed the clinical and accuracy checks and who had 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. 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. Information identified during the dispensing process such as a new medicine or a dose change was written down 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. The team promoted the NHS hypertension case finding service through posters clearly displayed in the retail area. The pharmacist kept different size cuffs for the blood pressure monitor. This helped to ensure everyone who attended for the service had their blood pressure correctly measured.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines so the team, and the person collecting the medication, could check the supply. The pharmacy 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. Team members sent people a text message to advise them when their prescription was ready to collect. And they kept a record of the delivery of medicines to people. 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.

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 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. 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) via email. Team members printed off the alert, actioned it and kept a record.

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 blood pressure monitor that was regularly checked to ensure it gave accurate readings. The pharmacy had two fridges for holding medicines requiring storage at this temperature. One fridge held stock and had a glass door that enabled the team to view stock without prolong opening of the door. The other fridge held completed prescriptions awaiting to be supplied. A notice on the door of this fridge advised the team to get a second check of the dispensed medication before handing it to the person.

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 private 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.