General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 54-56 High Street, SKIPTON, North Yorkshire, BD23 1JP

Pharmacy reference: 1039006

Type of pharmacy: Community

Date of inspection: 13/03/2023

Pharmacy context

This pharmacy is on a high street in Skipton. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They supply some medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes. The pharmacy provides people with other services such as the NHS New Medicines Service (NMS) and it delivers medicines to people's 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 adequately identifies and manages risks to its services. It has the written procedures it needs to help pharmacy team member manage these risks. Team members understand their role in protecting vulnerable people. And they suitably protect people's confidential information. Team members record and discuss their mistakes to make sure they learn from them. But they don't always capture key information in these records to help aid future reflection and learning.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. The SOPs were available to pharmacy team members electronically. Team members received new and updated SOPs each month to read via the company's online training portal. Each procedure was accompanied by an assessment to test people's understanding. Pharmacy team members confirmed their understanding by passing the assessment. They were clear about how to access the procedures online if they needed to refer to them. The pharmacy was providing the NHS New Medicines Service (NMS) for people. There was no documented risk assessment (RA) of the service available in the pharmacy. Team members explained how a formal RA was completed at head office level but was not available for them to refer to. So, they were unable to make changes to it, considering emerging risks as the service was provided. Team members had considered and discussed some risks, such as making sure that the consultation room was suitable to provide the service from. And making sure team members had completed the necessary training. There was a written SOP available to help team members manage the risks. The pharmacist recorded some information about their consultations and the interventions they made when providing the service to people. But they sometimes did not record detailed information to help deal with future queries. For example, one record seen did not record why someone had stopped taking their new medicine shortly after it was prescribed. The pharmacy received a bulletin approximately every month from the company's professional standards team, called "The Professional Standard", which communicated professional issues and learning from across the organisation following analysis of near miss and errors. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed the front of each bulletin to record that they had done so. A recent example had included sharing learning to help improve team member's professional decision making when providing medicines to people over the counter.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They used an electronic system to record their near miss errors. And the data collected was uploaded to a centralised system to help aid analysis. Pharmacy team members explained they discussed their errors and why they might have happened. But in the records seen, they sometimes did not capture this information to help inform the analysis process. Team members sometimes made changes following errors. In several examples, they had identified that errors occurred due to distractions and made changes regarding answering the telephone and helping people at the pharmacy counter. This helped reduce distractions when dispensing. If a team member was distracted from their dispensing task, they completed a double check of all their work to help identify any errors they had made. The pharmacy's new manager was aware that a small number of errors were still being caused by distractions. And they were working

hard with the team to reinforce the measures put in place to help manage the risks of unavoidable distractions. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available did not include much detail about the causes of errors and the actions taken by team members to help prevent them happening again. Team members gave their assurances that these aspects were always discussed, and changes implemented where possible.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected by asking people to complete customer surveys and questionnaires. And any complaints were immediately referred to the pharmacist to handle. There was information available for people in the retail area about how to provide the pharmacy with feedback. Team members did not have any examples of any changes they had made to improve their services in response to people's feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy maintained a register of CDs returned by people for destruction, and this was accurately completed. The pharmacy maintained a responsible pharmacist record, which was also up to date and completed accurately. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. They explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training each year. And they had access to information explaining how to contact local safeguarding teams for advice.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably qualified for their roles and the services they provide. And they complete ongoing training to keep their knowledge and skills up to date. The pharmacy team are generally able to manage the workload. But the minimal staffing levels means team members sometimes have to manage several tasks at once, so may not always work effectively.

Inspector's evidence

During the inspection, the pharmacy team members present were a pharmacist, a full-time pharmacy technician who was also the store manager, and a part-time dispenser. The pharmacy also employed a further full-time pharmacy technician and part-time dispenser who were not present during the inspection. The pharmacist and pharmacy manager were new to the pharmacy. Team members explained there had been improvements in how the pharmacy was operating since their new manager and pharmacist had been appointed. And this was because they now had effective leadership to help manage the workload. During the inspection, pharmacy team members often found it difficult to allow time to speak to the inspector. They were continually distracted and interrupted when carrying out their dispensing activities to serve people at the pharmacy counter and answer queries. And people frequently presented at the pharmacy counter to purchase items that did not require the expertise of a pharmacy team member. Pharmacy team members managed the workload to the best of their capacity. But for a significant proportion of the inspection, there was a queue of people at the counter waiting to be served. This was discussed with the manager who explained the pharmacy was operating with one pharmacy team members less than normal due to annual leave.

Team members completed mandatory e-learning modules regularly. Their latest modules included training on information governance and security. And they also regularly discussed learning topics informally with each other. The pharmacy had an appraisal process in place for pharmacy team members. Team members had a meeting twice a year with their manager to discuss their performance and learning needs. And they set objectives to address any learning needs identified. Team members explained they would also raise any learning needs informally with the pharmacy manager, who would support them to access the right resources to complete their learning.

A team member explained how they would raise professional concerns with the pharmacist, the area manager, or the regional manager if necessary. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy, and pharmacy team members knew how to access this. The team communicated openly during the inspection. Team members were asked to achieved targets in various areas of the business, for example relating to the number of prescription items dispensed, and the number of professional services delivered. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely. And explained they were comfortable to have conversations with their area manager if they did not achieve their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides an adequate space for the services it provides. The pharmacy has a suitable room where pharmacy team members can speak to people privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were mostly tidy and well organised. The pharmacy’s floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a room elsewhere in the store which pharmacy team members used to prepare and store multi-compartment compliance packs. This room was included in the pharmacy’s registered premises. The pharmacy had a private consultation room, which was clearly signposted and pharmacy team members used the room to have private conversations with people. The store also had a storeroom that was not part of the pharmacy’s registered premises. Pharmacy team members used this room to store some general sales list (GSL) medicines as well as other items of stock for the rest of the retail area. There was a clean, well-maintained sink in the dispensary used for medicines preparation. Team members had access to a toilet elsewhere in the building, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept heating and lighting to acceptable levels. Overall, the pharmacy's appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people, including people using wheelchairs. The pharmacy has systems in place to help provide its services safely and effectively. These include processes to help ensure people's medicines are suitable for them, and that they receive appropriate advice. It sources its medicines appropriately. And it stores and manages its medicines properly.

Inspector's evidence

The pharmacy had access from the street through automatic doors. Pharmacy team members could use the patient medication record (PMR) system to produce large-print labels to help people with visual impairment. And they said they would use written communication with someone with hearing impairment to help them access services. The pharmacy also had a hearing induction loop available for people to use.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. And they signed boxes printed on each prescription token. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. Pharmacy team members used alert cards to highlight certain aspects of a prescription. These included highlighting an item that required storage in a fridge, a controlled drug (CD), or various high-risk medicines such as warfarin and valproate. Pharmacy team members also attached a sticker to prescription bags containing CDs. They wrote the expiry date of the prescription on the sticker to help prevent the medicines being given out after the prescription had expired. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme. The pharmacy had information materials to give to people to help them understand the risks of taking valproate.

The pharmacy supplied medicines to some people in multi-compartment compliance packs. It attached labels to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Team members documented any changes to medicines provided in packs on the person's master record sheet. This was a record of all their current medicines, where they should be placed in the packs and the times they needed to be taken. The pharmacy delivered medicines to people via a delivery driver who they shared with several other local stores. It used an electronic system to manage and record deliveries which uploaded information to the driver's handheld device. Pharmacy team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy

team members checked medicine expiry dates in various areas of the pharmacy every week on a rolling cycle. And this meant they checked all medicines every three months. They recorded their checks. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring medicines during the month before their expiry. The pharmacy responded to drug alerts and recalls. It quarantined any affected stock found for destruction or return to the wholesaler. It recorded any action taken. Records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.