General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7 Monks Cross Shopping Park, Monks Cross Drive, York, North Yorkshire, YO32 9LF

Pharmacy reference: 1039049

Type of pharmacy: Community

Date of inspection: 15/05/2023

Pharmacy context

The pharmacy is on a retail park near the centre of York. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members also provide other healthcare services including various vaccinations and the NHS Blood Pressure Check service. The pharmacy delivers medicines to people's homes.

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 effectively identifies and manages risks to its services. It has clear systems and procedures in place 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 the mistakes they make to learn from them. But they don't always capture key information in these records to help aid future reflection and additional learning.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The company was in the process of updating its SOPs and migrating them to an online platform. Pharmacy team members received new and updated SOPs each month to read via the online training system. Each procedure was accompanied by an assessment to test people's understanding. Pharmacy team members confirmed their understanding by passing the assessment. They knew how to locate the procedures if they needed to refer to them. The pharmacy received a bulletin every month from the company's professional standards team, called "The Professional Standard", which communicated professional issues and learning from across the organisation. 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 confirm they had done so. A recent example of a case study highlighted the importance of counselling people properly to help them take their medicines safely.

The pharmacy provided a popular vaccination service to people. The service included vaccinations for travel, such as hepatitis, meningitis, and yellow fever, and for other conditions such as chickenpox and flu during the winter season. The pharmacy had considered the risks of delivering vaccinations to people. The pharmacist explained how they assessed various risks, such as the suitability of the pharmacy's consultation room, ensuring that people had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis. The pharmacist explained they were new to vaccinating, and they regularly discussed the service with more experienced colleagues to help improve their knowledge. They also clearly explained how they would escalate an incident while they were providing the service to make sure others could learn and improve.

Pharmacy team members highlighted and recorded near miss 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 helping people at the pharmacy counter. This helped reduce distractions when dispensing. The pharmacy manager was aware that a small number of errors were still being caused by distractions. They were working hard

with the team to reinforce the measures put in place to help manage the risks of unavoidable distractions. And to evaluate the pharmacy staffing structure to help protect team members preparing prescriptions from 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 were 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. 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 correctly completed. It 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. And they accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags, which 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. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. And they completed mandatory training on this 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.

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. Pharmacy team members are generally able to manage the workload. But they are sometimes working under pressure and are often required to manage several tasks at once, so may not always be working in the most efficient way.

Inspector's evidence

During the inspection, the pharmacy team members present were a pharmacist, a full-time trainee dispenser and a part-time trainee medicines counter assistant. Also present was the store manager and deputy store manager, who were both qualified dispensers but were not available to work in the pharmacy all the time. The pharmacy also employed a further part-time dispenser, one full-time and one part-time trainee dispenser and one part-time trainee medicines counter assistant, who were not present during the inspection. During the inspection, pharmacy team members 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 currently reviewing its staffing structure and was working hard to train new pharmacy team members.

Team members completed mandatory e-learning modules regularly. The latest modules included training on information governance, safeguarding and incident management and reporting. And they also regularly discussed learning topics informally with each other. Team members read new and revised standard operating procedures (SOPs) via the company’s online training platform. And were required to pass a short test after reading each SOP to confirm their understanding. The pharmacy had an appraisal process in place for pharmacy team members. Team members had a meeting every year with their manager to discuss their performance. And they set objectives to address any learning needs identified. Team members explained they would also raise any learning needs informally with the pharmacist, who would support them to access the right resources to help improve their knowledge.

A team member explained how they would raise professional concerns with the pharmacist, the store manager, the area manager, or the professional standards pharmacist 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. A recent example of this was changes the team had made to the layout of the pharmacy to help improve workflow and make the best use of the space available. 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 they felt comfortable having conversations with their area manager if they did not always achieve their

targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable 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 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 consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. Team members also kept the room locked when it was not being used to prevent unauthorised access.

There was a clean, well-maintained sink in the dispensary used for medicines preparation. 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. 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 operates and provides its services safely. It has processes in place to help ensure people receive appropriate advice and information about their medicines. The pharmacy sources its medicines appropriately. And it stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the retail park through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. And they signed a quadrant printed on the prescription. 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 various alert cards to highlight different aspects of a prescription. These included highlighting an item that required storage in a fridge, a controlled drug (CD) and some high-risk medicines such as warfarin and sodium valproate. Pharmacy team members also attached a sticker to prescription bags containing CDs. They wrote the expiry date of the prescription on the sticker. This was 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 and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them understand the risks of taking valproate.

The pharmacy supplied medicines for people in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs 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. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for several other local stores. The pharmacy used an electronic system to manage and record deliveries and it 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, asking them to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings, and the temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they

checked all stock medicines every three months. They highlighted and recorded any short-dated items up to three months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items during the month of their expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It also had reference resources available, including 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.