General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 25b The Village, Strensall, YORK, North Yorkshire, YO32 5XR

Pharmacy reference: 1039067

Type of pharmacy: Community

Date of inspection: 31/10/2022

Pharmacy context

The pharmacy is on a high street in Strensall, near York. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines for people in multi-compartment compliance packs to help them take their medicines correctly. And they deliver medicines to people's homes. The pharmacy provides seasonal flu vaccinations for people.

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 adequately identifies and manages risks to its services. And it has the written procedures it needs relevant to its services. Pharmacy team members understand their role to help protect 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 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 portal. Each procedure was accompanied by an assessment to test people's understanding. Pharmacy team members confirmed their understanding by passing the assessment. Pharmacy team members were clear about where the procedures were kept if they needed to refer to them. The pharmacy was providing a seasonal flu vaccination service for people. It had completed a risk assessment (RA) to help minimise the risks of delivering the service to people. But there was not a documented RA 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. The pharmacy had up-to-date patient group direction (PGD) documents available for both the NHS and private flu service. Pharmacy team members delivering the services had also completed the necessary face-to-face training. This included a period of supervised practice to confirm their competence to administer vaccinations. And they had completed theory training online.

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 captured little of this information to help inform the analysis process. Team members made changes following errors. In one example, 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 recorded dispensing errors, which were errors identified after the person had received their medicines. The records available showed little 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 verbally and by using comment cards given to people at the pharmacy counter. The pharmacy had recently responded to some feedback received from people about there being nowhere in the village available for people to obtain a flu vaccination. This meant people were having to travel several miles to neighbouring towns and

villages. The feedback prompted the pharmacy to review their workload and capacity to be able to provide a flu vaccination service. One current issue was that the pharmacy did not have a regular pharmacist. This meant locum pharmacists were not always accredited to provide flu vaccinations on an ad hoc basis. Their review resulted in the pharmacy now offering a service to the local community one day a week, on a day where an accredited pharmacist worked at the pharmacy regularly. The pharmacy operated a booking system to help organise their vaccinations efficiently to be able to provide as many as possible while managing the rest of the pharmacy's workload.

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

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. Pharmacy team members had signed to confirm they had understood the procedure. 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the team members present were a locum pharmacist, one pharmacy technician, who was also the manager, and three dispensers. And they were observed to manage the workload well. Team members completed mandatory e-learning modules regularly. Their latest modules included training on information governance and customer service. And they also regularly discussed learning topics informally with each other. They also regularly 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 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 pharmacy manager, the area manager, or the pharmacist on duty 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. Team members had recently introduced a rota following a suggestion. This meant all team members had the opportunity to work in all areas of the pharmacy regularly to help them remain multiskilled. They hoped this would reduce the risks of errors by them being more confident in all tasks. And it would help them to cover each other's absences more effectively. The pharmacy had a whistleblowing policy. Pharmacy team members knew how to access the procedure. Pharmacy team members communicated openly during the inspection. They were asked to achieved targets in various areas of the business, for example the number of prescription items dispensed, and the number of flu vaccinations 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 a suitable space for the services it provides. The pharmacy has a suitable room where pharmacy team members 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 free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room available, which was clearly signposted. Pharmacy team members used the room to have private conversations with people.

There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall 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 via a small step. It had a bell at the door for people to use to attract attention if they needed help accessing the premises. 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. Pharmacy team members also highlighted various pieces of information on prescriptions to help prevent mistakes happening. These included highlighting quantities of the quantity of medicines prescribed differed from the quantity in a sealed original pack. And highlighting the form of a medicine if the form prescribed was less common, such as ramipril tablets instead of capsules. 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 contraception. The pharmacy had stock of some information materials to give to people to help them manage 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). Team members kept records of communications they had with the GP surgeries and others about people’s medicines, to help resolve future queries quickly. 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. 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 medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items during the month before 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 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.