General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 202 Haworth Road, BRADFORD, West Yorkshire, BD9 6NJ

Pharmacy reference: 1039454

Type of pharmacy: Community

Date of inspection: 15/06/2022

Pharmacy context

The pharmacy is in a parade of shops in a residential suburb of Bradford. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs to help them take their medicines correctly. And they deliver medicines to people's homes. The pharmacy provides people with services via the NHS Community Pharmacist Consultation Service (CPCS). And provides a substance misuse and needle exchange 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 has appropriate procedures in place to help manage the risks in the pharmacy. And it keeps the records required by law. Pharmacy team members record the mistakes they make during dispensing. And they suitably discuss and reflect on these mistakes to make changes to help prevent similar mistakes from happening again. They understand their responsibilities in protecting people's private information and they keep this information safe. And they know how to help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The superintendent pharmacist's (SIs) office had reviewed the sample of procedures seen in 2020 and 2021. And had scheduled the next review of the procedures for 2022 and 2023. Pharmacy team members had read the procedures. And they had signed each one to confirm their understanding. Pharmacy team members were clear about where the procedures were kept if they needed to refer to them. The pharmacy defined the roles of the pharmacy team members based on their levels of qualification in each SOP. Pharmacy team members also had their responsibilities defined verbally through discussion each day. The pharmacy received a bulletin approximately every two months from the company's professional standards team, called "The Professional Standard", communicating professional issues and learning from across the organisation because of near miss and error analysis. 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. The pharmacy had completed a risk assessment several times during Covid-19 pandemic to help them manage the risks of infection. The latest had been completed in August 2021 and was displayed for everyone to see. Pharmacy team members continued to regularly wear masks while they worked. They regularly cleaned surfaces in the pharmacy. And there was a plastic screen at the pharmacy counter to help prevent the spread of infection.

The pharmacy was required by head office to complete an online self-audit checklist every quarter. Each audit asked the pharmacy different questions about how they were managing certain risks and governance arrangements. For example, how they were managing near miss errors, how they were managing controlled drugs (CDs) and their records, and how the team were complying with SOPs. The pharmacy was scored based on their responses. And any issues were addressed by the pharmacy completing their own action plan to make any necessary improvements. The pharmacist showed some examples of issues they had identified recently. And there was evidence that these issues had been addressed and resolved.

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 discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines on the shelves, to help prevent the wrong medicines being selected. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future

learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. They had identified a common cause of near miss and dispensing errors over several months as being distractions and being broken off from dispensing to serve people at the pharmacy counter. In response, Pharmacy team members had discussed the way they were working to help establish if they could manage interruptions more effectively. They decided to process prescriptions differently, including in different areas of the pharmacy. For example, they used the workstation closest to the pharmacy counter to process prescriptions of up to three items. This meant the person working at this station could process a prescription more quickly, giving them more time to respond to people at the counter. Prescriptions with more items were managed by another team member, using a workstation further from the counter. This meant they were less likely to be distracted and interrupted from processing the prescription. The pharmacist's checking station was further from the counter again, to help minimise distractions at the checking stage. Team members changed who answered the telephone with the person carrying out the least risky activity responsible for answering, including the pharmacist. Pharmacy team members explained these changes had worked well. They had noticed a marked reduction in distractions and the number of errors had reduced.

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. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback. The manager explained that the pharmacy often received very positive feedback from people, which they shared with the team. And this had positive impact on the team, especially recently as they dealt with the pressures during the Covid-19 pandemic.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete 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 complete and up to date. The pharmacy maintained a responsible pharmacist record. And this was also complete and up to date. 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 sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. Pharmacy team members 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 symptoms 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 concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years and had last completed training in 2020.

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 some appropriate training to help keep their knowledge and skills up to date. And they share and discuss their learning with each other. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

During the inspection, the pharmacy team members present were the responsible pharmacist and two dispensers. The pharmacist manager was also present for part of the inspection. Pharmacy team members completed mandatory e-learning modules at least every three months. The pharmacy also had a suite of e-learning modules that team members could choose to complete to help improve their knowledge. Pharmacy team members also regularly discussed learning topics informally and the pharmacists highlighted topics for team members to learn more about. Pharmacy team members recently completed Dementia Friends training and updated their knowledge of sun care. They took time during work to complete mandatory training. But they explained it was difficult to find time at work to complete any optional training. Pharmacy team members received an appraisal with the pharmacy manager once a year. They had a meeting with the manager every three months to monitor their progress, allowing them to reflect on their own performance and identify their own learning needs. Team members set objectives at each appraisal to work towards, for example to develop their confidence when handing prescriptions out to people and in giving healthcare advice to people.

A pharmacy team member explained how they would raise professional concerns with the pharmacists, the area manager or the pharmacy superintendent's office if necessary. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. One recent example was pharmacy team members changing the way they filed and stored prescriptions being processed to help prevent them being mixed up. And to make them easier to find when people arrived to collect their prescriptions. They had also started to highlight prescriptions to identify prescriptions for people with the same name, and often at the same address, but with a different date of birth, for example father and son. This helped to prevent people receiving the wrong medicines. The pharmacy had a whistleblowing policy. Pharmacy team members knew how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection.

The manager explained the company set the team targets to achieve in various areas of the business. These included number of prescriptions items dispensed, the services they provided, and the number of people nominated to use the pharmacy to have their electronic prescriptions dispensed. The manager explained the team were given autonomy to manage their targets appropriately.

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 people can speak to pharmacy team members 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. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

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. It sources its medicines appropriately. And it stores and manages its medicines properly.

Pharmacy team members manage the pharmacy's services well to make sure people quickly receive the right care.

Inspector's evidence

The pharmacy had access from the street through automatic doors via a step. The pharmacy had a portable ramp available to help people who used a wheelchair or who could not manage the step. Pharmacy team members explained that people knocked on the door to attract their attention if they needed help. 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 were also able to speak several languages spoken locally, including Urdu, Punjabi, Gujarati, Marathi and Hindko as well as English. And they could use an online translation service to help communicate with people who spoke other languages, such as Polish.

Over the last 12 months, pharmacy team members had worked hard to develop and strengthen their relationships with local surgeries. They had been prompted to do this by increasing difficulties contacting surgeries to resolve prescription queries. These developments meant they had been able to identify and build relationships with key people at the surgeries, such as nominated people to contact to resolve queries about prescriptions for people who received their medicines in multi-compliance compliance packs. And the practice pharmacist to help resolve clinical queries. They had also been able to establish email contact routes for some surgeries, which was providing a more efficient communication route and was helping to provide answers to queries more quickly.

People were referred to the pharmacy for some services via the NHS Community Pharmacist Consultation Service (CPCS). Pharmacy team members had received a briefing about the service before it had commenced in June 2021. And they explained the system clearly. Pharmacy team members had read and understood the SOP for the service, which was in place to help them manage the risks. The pharmacy had carried out a risk assessment before starting to deliver the service. Pharmacy team members used a checklist, provided by head office, to identify the key risks associated with providing the service to people. They explained that no adjustments had been required after the risk assessment. People were referred to the pharmacy, most commonly by NHS111, to access urgent supplies of medicines and for advice about minor ailments. The pharmacist completed a consultation with people. And decided how to respond to their need most appropriately. The pharmacist gave some examples of situations where they had referred people to other services because they were unable to provide people with the best care. One example was a request for a medicine that the pharmacy did not have in stock. Pharmacy team members contacted several local pharmacies until they found one who did stock the medicine. And they referred the person to that pharmacy instead so they could receive their emergency medicines quickly. Another example was someone who was referred to the pharmacy with

various symptoms. After consultation, the pharmacist was concerned the person was showing symptoms of appendicitis. So, they referred the person urgently to the local accident and emergency department for urgent assessment. The pharmacy recorded all their consultations and referrals.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. 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 various 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. 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 give 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 stock of information materials to give to people to help them manage the risks of taking valproate. The pharmacist asked to see information from someone's latest blood test results if they were receiving warfarin. They checked to make sure their results were within the correct range and they recorded the information before dispensing their medicines.

The pharmacy supplied medicines to 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. 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. 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 where they were placed in the packs. They also recorded this on their electronic patient medication record (PMR). Team members kept records of communications they had with the GP surgeries about people's packs, to help resolve future queries quickly. The pharmacy delivered medicines to people via a delivery driver that 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, asking them 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 recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members recorded checks of medicine expiry dates that they made in various areas of the pharmacy every week 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 four months before their expiry. And they removed expiring items during the month before their expiry. The pharmacy responded to drug alerts and recalls. It quarantined any affected stock for destruction or return to the wholesaler. And it recorded any action taken. The 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 some equipment available to help prevent the transmission of Covid-19. These included hand sanitiser and plastic screens. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had a suitable container available to collect and segregate its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view.

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.