General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 22 King Street, HUDDERSFIELD, West Yorkshire, HD1 2QE

Pharmacy reference: 1039605

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

The pharmacy is in a pedestrianised shopping area in Huddersfield town centre. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they provide travel vaccinations and anti-malarials, sometimes in conjunction with prescriptions from Boots online prescribing service. The pharmacy provides seasonal flu and pneumonia vaccinations. And, provides various other vaccinations services, including for chickenpox, meningitis and human papilloma virus (HPV). Pharmacy team members supply medicines to people in multi-compartment compliance packs. They provide a substance misuse service. And, they deliver 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	2.2	Good practice	The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. And, they are provided with regular feedback to help them improve. They reflect on their own performance, discussing any training needs with the pharmacist and other team members.
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 procedures to identify and manage risks to its services. And, pharmacy team members follow them to complete the required tasks. The pharmacy asks people using the pharmacy for their views. And, it acts to make improvements after feedback is received. The pharmacy protects people's confidential information. And, it keeps the records it must by law. Pharmacy team members record and discuss mistakes that happen. They use this information to learn and reduce the risk of further errors. And, they read about mistakes that happen elsewhere to improve their practice. But, they don't always collect information about the causes of mistakes to help inform the changes they make. So, they may miss opportunities to improve. The pharmacy team members know how to help safeguard the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the pharmacy superintendent reviewed them regularly. The sample checked were last reviewed in 2017 and 2018. And the next review was scheduled for 2019 and 2020. Pharmacy team members had signed to confirm they had understood the SOPs since they were last reviewed. The pharmacy defined the roles of pharmacy team members in each procedure. And, pharmacy team members allocated daily tasks by having discussions throughout the day. The pharmacy had up-to-date SOPs and signed documents for the vaccination services being delivered via patient group direction (PGD). And, it had a declaration of competence from the authorised pharmacists confirming their training was up to date. Pharmacists completed theoretical training every two years. And, flu vaccination training every year, which included practical vaccination administration training.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members also sometimes recorded their own mistakes. They discussed the errors made. And, they discussed why the error might have happened. They used this information to inform the changes they made to help prevent a recurrence of the error. A dispenser explained one change he had made while preparing multi-compartment compliance packs after he had missed an item from a compartment. He had added a count of the number of items in each compartment to his process, to help identify if anything was missing. But, pharmacy team members did not record much detail about why a mistake had happened, to help during the analysis of the data collected. The pharmacy technician and pharmacist analysed the data collected about mistakes every month. And, they made changes based on the patterns they found. But, they did not analyse the data for patterns of cause. They discussed the patterns identified with the team at a monthly patient safety briefing. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system called PIERS. In the sample of records seen, pharmacy team members gave a clear description of what had happened, who had been involved and the causes of each error. They discussed all dispensing errors at the following patient safety briefing. And, they made sure that all team members were aware of the risks and the changes required to help prevent the mistake happening again. Pharmacy team members explained that they raised risks or issues they noticed to each other throughout the day, either verbally at the time or in the following days briefing, to help prevent errors. One recent example was a team member had noticed a pack on the shelves that had not been marked as split pack before being put away.

Pharmacy team members used a system of “Pharmacist Information Forms” (PIFs) to communicate messages to the pharmacist that they had seen on the patient's electronic medication record. They recorded information such as whether the medicine was new to the patient and whether any changes had been made since the last time they received it. They also recorded whether the patient had any allergies and whether they were eligible for services, such as a medicine use review (MUR). The form had a blank box to write any further information that the dispenser thought the pharmacist should be aware of. For example, pharmacy team members were required to write the name of any look-alike and sound-alike (LASA) medicines on the PIF. Once they had dispensed the item, they ticked the name on the PIF to confirm they had performed a check of their own work to make sure it was correct. Then, the pharmacist signed the PIF to confirm they had also checked that the correct LASA medicine had been dispensed. The pharmacy had a list of LASA medicines attached to each workstation. Pharmacy team members attached “Select and Speak” stickers to the shelves and drawers in front of LASA medicines to highlight the risks during the dispensing process. They had also placed ‘CD’ stickers in front of controlled drugs (CDs) where the prescription had a 28-day expiry, for example gabapentin and pregabalin.

The pharmacy had a daily and weekly audit in place as part of its governance arrangements. The pharmacist completed a checklist looking at various aspects of the pharmacy procedures. For example, they checked the responsible pharmacist (RP) records, controlled drug (CD) security and that the pharmacy was protecting people’s confidential information. There were no findings for improvement in the recent examples seen. Pharmacy team members received a bulletin approximately every month from the company 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 and any learning as a result. One recent case study was about separating quetiapine from other medicines after an error had been made elsewhere in the company. Pharmacy team members read the bulletin and signed the front to record that they had done so.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company’s complaints procedure. It collected feedback from people by using questionnaires. The pharmacy printed a link to the questionnaire on the back of each till receipt. One recent example of feedback was about the time people waited at the pharmacy counter to be served. The pharmacy manager explained that they had adjusted the staff rota to make sure there was always someone at the pharmacy counter to help people quickly. And, the pharmacy team members had discussed the feedback and were now more aware to respond quickly if the person at the counter asked for help.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It 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 on paper. And it was 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 private prescription and emergency supply records electronically. And, these were complete and up to date. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected by a contractor and sent for destruction. Pharmacy team members had been trained to protect

people's privacy and confidentiality. They completed e-learning every year. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR).

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to the company's internal process or local safeguarding teams to get advice. The process was displayed in the dispensary. The pharmacy had contact details available for the local safeguarding service and the company's internal safeguarding advisors. Pharmacy team members completed mandatory training every year. Registered pharmacists and pharmacy technicians also completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years. The pharmacist had last completed their training in 2017.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. And, they are provided with regular feedback to help them improve. They reflect on their own performance, discussing any training needs with the pharmacist and other team members. And, they support each other to reach their learning goals. Pharmacy team members feel able to raise concerns and use their professional judgement.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists, a pharmacy technician, three dispensers, one of which was the deputy store manager, and a trainee dispenser. Pharmacy team members completed mandatory e-learning modules each month. And these covered various pharmacy topics, including mandatory compliance training. The modules covered health and safety, customer service, information governance, and other health related topics. Each month, the pharmacy received an activity sheet about a specific topic to help pharmacy team members develop their knowledge of the subject. The most recent example was about children's medicines. The activity sheets included exercises, discussion prompts and case studies for all pharmacy team members to complete, including the pharmacist. Pharmacy team members read the information provided. Then they discussed the topic with the team. And, they had more directed discussions about each learning topic with the pharmacy's nominated patient safety champion. The pharmacy technician explained they routinely observed pharmacy team members having conversations with people about medicines, their prescriptions, or queries about their health. She said she usually observed team members without their knowledge, so she could observe a true refection of their behaviour. And, she recorded her observations using a survey. Once completed, she discussed her observations with the pharmacy team member to help them to improve and change their techniques if necessary. One recent example she provided was her observing a pharmacy team member handing out a prescription to someone. The team member asked the person to confirm their address. But, they did not ask them to confirm their postcode, in accordance with the procedure to help prevent medicines being handed to the wrong person. She discussed her observations with the team member. And, they discussed and refreshed their knowledge of the correct technique. The technician observed the pharmacy team member the following week, from a distance and without their knowledge. And, she observed them handing out medicines using the correct procedure.

The pharmacy had a yearly appraisal process. Pharmacy team members discussed their performance with the manager and were given the opportunity to identify any learning needs. They then set objectives to address their needs. A team member gave an example of a one of their objectives. She explained she had identified the need for her to obtain more experience of coaching people. She discussed this with her manager, who was supporting her to have more opportunities to practice her coaching skills. A dispenser explained how he would raise professional concerns with the pharmacist, pharmacy manager or area manager. He said he felt comfortable raising a concern. And confident that his concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And, the team knew how to raise a concern. The pharmacy team communicated with an open working dialogue during the inspection. Pharmacy team members

explained a change they had made after they had identified areas for improvement. They had identified problems with the way creams and inhalers were being stored in the pharmacy. They discussed the issues. And, they changed the ways the items were being stored to help reduce the amount of stock in the pharmacy. And, they had reorganised the areas where they were kept helping prevent having to owe items to people unnecessarily.

The pharmacy asked the team to achieve targets. Targets included the number of patients who nominated the pharmacy to receive their electronic prescriptions, the number of medicine use review and new medicines service consultations completed, and the number of flu vaccinations provided. Pharmacy team members were rated for compliance with targets using a score card. They discussed progress amongst the team and with the area manager, who supported them to reach their goals. And, felt the targets were achievable.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team 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 elsewhere in the store, which had a sink providing hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And, the pharmacy has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They manage this service well. And, they provide these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the pedestrianised shopping area through automatic doors. Pharmacy team members were able to provide large-print labels and instruction sheets for people with a visual impairment. And, there was a hearing induction loop for people with a hearing impairment to use. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached labels to each pack, so people had written instructions about how to take the medicines. And, it added the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's master record. And, in a communications diary. Each set of packs prepared was accompanied by a collection docket. Pharmacy team members used the docket to record when someone had collected their pack from the pharmacy. And, it helped them to keep track of when they needed to order the next batch of prescriptions for the following cycle of packs. If there was a query with someone's prescriptions or packs, pharmacy team members placed a basket containing the prescriptions and any affected packs in a holding area. The basket was accompanied by a quarantine card. Pharmacy team members used the card to document what the query was. And, the progress team members had made to resolve the query. This system also helped to prevent packs being dispensed by mistake before any queries had been resolved.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels and signed in a quadrant printed on each prescription. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent people's prescriptions being mixed up. The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three to six months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for

destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

Pharmacy team members used various alert cards that were added to a prescription basket during the dispensing process. For example, one card alerted staff to the presence of a controlled drug on the prescription, others to there being warfarin or lithium on the prescription that required further advice or monitoring. Staff requested any monitoring information and the pharmacist then made a clinical decision and made a record of the information provided. Pharmacy team members highlighted prescriptions for controlled drugs (CDs) with a sticker on the bag and on the accompanying pharmacist information form (PIF). And a CD alert card was attached to the bag, which also had the expiry date of the prescription written on. This included prescriptions for schedule 3 CDs such as tramadol, gabapentin and pregabalin. They stored dispensed CD and fridge items in clear plastic bags to facilitate a further check of the product against the prescription by the pharmacist and the patient as the item was handed out. The pharmacy team member handing the medicine out asked the patient to confirm that the product was what they were expecting. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, he checked if the person was aware of the risks if they became pregnant while taking the medicine. He advised he would also check if they were on a pregnancy prevention programme. The pharmacy had some printed information material to give to people and to help highlight the medicine during dispensing. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They were aware that they were going to receive training on the subject but did not know when this would be. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. And, the pharmacy had the right equipment in place. Pharmacy team members said they were expecting a phased rollout of the system soon.

The pharmacy delivered medicines to people using a hub driver based at another store. Pharmacy team members populated the delivery records and uploaded them to the driver's electronic device. They also printed each run sheet, which was signed by the driver to confirm collection. Deliveries were signed for by the recipient on the driver's electronic device and records were held centrally. Records of receipt could be requested if necessary. CD deliveries were signed for on a separate, paper docket and records were returned to the pharmacy after each delivery run.

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 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 a separate set of measures to dispense methadone. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge that was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment. And, they stored all items securely.

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.