General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 37-39 Brook Street, ILKLEY, West Yorkshire, LS29 8AG

Pharmacy reference: 1039638

Type of pharmacy: Community

Date of inspection: 12/12/2019

Pharmacy context

The pharmacy is on a high street in the centre of Ilkley. Pharmacy team members 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 people with seasonal flu vaccinations. Pharmacy team members supply medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes. The pharmacy provides a substance misuse 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	2.2	Good practice	The pharmacy provides access to a range of comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. And they receive regular feedback to help them improve their performance and identify any training needs.
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. They complete a weekly audit of their key governance and safety tasks. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They protect people's confidential information. And keep the records they 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 discuss or record enough detail about why these mistakes happen. So, they may miss opportunities to improve.

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 2018. And the next review was scheduled for 2020. Pharmacy team members had signed to confirm they had read and 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 flu vaccination service 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 near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. And, they sometimes recorded brief information about the causes of the errors. But, this didn't always happen. A common cause of mistakes recorded was distractions and interruptions. Pharmacy team members had not been specific about what the distractions were. And their most common solution to prevent future errors was to try not to be distracted and to finish their task before serving someone else. The pharmacy technician analysed the data collected about mistakes every month. And the analysis was recorded as part of a monthly patient safety review. The information in examples seen discussed the patterns identified in the data collected about errors. But the analysis did not always discuss or attempt to rectify the patterns found. One example was an increase in the number of quantity errors being identified since the introduction of product scanning as part of a new electronic patient medication records system. This was discussed with the team. They agreed that pharmacy team members had sometimes become complacent, relying on product scanning to spot all errors. And sometimes not following their long-established manual safety checks. The pharmacist gave an assurance that she would work with the team to make sure they used product scanning in addition to their established patient safety procedures. 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. Pharmacy team members discussed mistakes that happened. And, they sometimes made changes to prevent them happening again. But the records of errors seen did not give much detail about why the mistakes had happened or what had been done to prevent them recurring.

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. Pharmacy team members explained that sometimes, they forgot to write the name of the LASA on the PIF. But they were working to improve this. 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.

The pharmacy had a daily and weekly audit in place as part of its governance arrangements. The pharmacy manager completed a checklist looking at various aspects of the pharmacy procedures. They tested the fire alarms, 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 identifying and taking more care when dispensing paediatric prescriptions.

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 verbally and by using questionnaires. A team member explained a recent change they had made after someone had made a complaint. The person had complained because he felt the pharmacy team members had not been discreet when he had asked to buy Viagra Connect. The person had raised concerns about where the product was kept behind the pharmacy counter. And about the information displayed on the front of the file of consultation documentation. Pharmacy team members had discussed the concerns raised. And they had moved the product to a more discreet location. They had changed the words on the front of the file of documentation. And had moved the file in to the dispensary, so pharmacy team members had to come and ask for the pharmacist to deal with the request.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these 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 records electronically. And the samples seen were complete and in order. They recorded emergency supplies of medicines electronically. Pharmacy team members 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. Pharmacy team members sealed the bags when they were full. And these

were collected by a specialist contractor and destroyed securely. Pharmacy team members had been trained to protect privacy and confidentiality. They were clear about how important it was to protect confidentiality. And the pharmacy had a procedure in place detailing requirements under the General Data Protection Regulation (GDPR). Pharmacy team members assessed the pharmacy for compliance with GDPR during each clinical governance audit. Pharmacy team members had individual login credentials to access the electronic medication records system. The computer terminals automatically logged out after a few minutes of inactivity.

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, local safeguarding teams or the area manager to get advice. The pharmacy had contact details available for the local safeguarding service. It had a procedure in place to instruct staff about how to deal with a safeguarding concern. Pharmacy team members completed mandatory training every year. Registered pharmacists were required to complete distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years. The pharmacist and pharmacy technician had last completed training in 2019.

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. 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 a pharmacist, a pre-registration pharmacist, a pharmacy technician, two dispensers, one of whom was the store manager, and a medicines counter assistant. Pharmacy team members completed mandatory e-learning modules each month. The modules covered various pharmacy topics, including mandatory compliance training covering health and safety, customer service and information governance. They completed learning on other health related topics often related to seasonal health conditions, such as flu, coughs and colds and children's health. 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. They explained they were supported by the pharmacist and colleagues to achieve their objectives.

The pharmacy technician explained she would raise professional concerns with the pharmacist, store manager or area manager. She felt comfortable raising a concern. And confident that her concerns 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 the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. They had identified that mistakes were being made because of distractions caused by people coming up to the pharmacy counter. So, they had moved some dispensing activities in to a room at the rear of the pharmacy. The room was closed from the rest of the store. And they explained this meant they were able to dispense multi-compartment compliance packs and electronic repeat prescriptions with fewer distractions.

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 they 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 also had room at the back of the premises. And pharmacy team members used the room to dispense multi-compartment compliance packs and repeat prescriptions. 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, which provided a sink with 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 in these packs. Pharmacy team members take steps to identify people taking high-risk medicines. They provide these people with relevant advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had ramped access from the street, through a power assisted door to help people access the pharmacy's services. Pharmacy team members said they would use written communication to help someone with a hearing impairment. They could produce large-print labels and instructions sheets to help people with a visual impairment.

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. 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. Another example was a card alerting staff to the presence of a medicine for children under 12 years old and the need for further advice and counselling when the prescription was handed out. And for the pharmacist to carefully check the dose prescribed. Pharmacy team members explained they were being more careful to use the paediatric alert card after discussing one of the recent case studies about mistakes with paediatric medicines. Pharmacy team members highlighted prescriptions for 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. 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. She checked if the person was aware of the risks if they became pregnant while taking the medicine. And gave them appropriate advice and counselling. The pharmacy had a supply of printed information material to give to people to help them understand the risks. The pharmacy supplied medicines 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 added the 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. The pharmacy team documented any changes to medicines provided in packs on the patient's master record sheet. And in a communications record book.

Pharmacy team members made a new master record sheet after each change to make sure the requirements were clear. The pharmacy technician explained they received most information about changes to packs from the GP in writing. And if they received information about a change verbally, they would confirm the changes with the prescriber before implementing them. She also explained that people were contacted every month before the pharmacy ordered their prescriptions. This was to ask them if they required any of their medicines that were not included in their pack, for example creams or inhalers. She explained they did this to help prevent people receiving items they didn't need. And to remind them to order prescriptions for their supplementary items themselves because the pharmacy could not order prescriptions for these items on their behalf. 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.

The pharmacy obtained medicines from three licensed wholesalers. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training on the subject. And they explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. The pharmacy had the right equipment and software in place. Pharmacy team members were regularly scanning packs and decommissioning medicines as part of their dispensing and hand-out process to comply with FMD. The pharmacy stored medicines tidily on shelves. And it kept all stock 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 cabinet 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. These were found to be correct.

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 months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. 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. The pharmacy responded to drug alerts and recalls. Any affected stock found was quarantined 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 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.