General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 22-28 Queens Way, KEIGHLEY, West Yorkshire, BD21 3PY

Pharmacy reference: 1039661

Type of pharmacy: Community

Date of inspection: 22/04/2024

Pharmacy context

The pharmacy is in a shopping centre in Keighley. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide other healthcare services including the NHS Pharmacy First Service and Covid-19 booster vaccinations. The pharmacy provides medicines to several local care and nursing homes. And it 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 with providing its services. It has written procedures relevant to its services to help team members provide them safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. They record and discuss the mistakes they make so that they can learn from them. And they capture key information to help them make effective improvements to the safety and quality of their services.

Inspector's evidence

The pharmacy was split over two floors in the same building. Most services and dispensing were provided by team members working in the ground floor area. The pharmacy's care homes services were provided by a dedicated team who worked in two rooms on the first floor. The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. These were available for team members online. Pharmacy team members received new and updated SOPs each month to read via the company's online training system. Each procedure was accompanied by an assessment to test people's understanding. 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, 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 to confirm they had done so. A recent example of a case study highlighted how team members could help people, including men, to manage the risks of taking sodium valproate by providing the right information.

The pharmacy provided the Covid-19 booster vaccinations for people. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the service, such as the suitability of the pharmacy's consultation area to deliver the service from. And ensured they had stock of the relevant medicines and had the necessary equipment available. They also ensured they had completed the necessary training and had the correct SOPs and supporting documents in place. Team members were prepared to manage people's expectations when they arrived at the pharmacy and complete the necessary screening questions with them. Team members explained they felt confident providing the service for people. They were clear about when to refer someone to the pharmacist. And how to manage people's confidentiality in the area of the pharmacy being used to deliver vaccinations.

Pharmacy team members highlighted and recorded mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. The pharmacy kept separate records of mistakes made in the ground-floor are of the pharmacy and in the first-floor care home services area. Team members used an electronic system to record their mistakes. And the data collected for each area was uploaded to a centralised system to help aid analysis. Pharmacy team members explained they discussed their mistakes and why they might have happened. And they captured some of this information in their records to help inform the analysis process. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available were comprehensive and included information about

why errors had been made and the changes implemented to help prevent a recurrence. The pharmacy's patient safety champions analysed data collected about near miss and dispensing errors each month to help identify patterns. These analyses were done separately for the ground floor area of the pharmacy and for the care home services area. Team members working in each part of the pharmacy discussed the patterns found at a monthly meeting and implemented changes to help prevent the same or similar errors happening again. But the two teams did not share learning with each other. So, opportunities to learn from mistakes and errors throughout the whole pharmacy may be lost. A recent example had been a pattern of quantity errors being made, caused by team members relying too much on the pharmacy barcode scanning technology to identify mistakes. To help address this, team members discussed the errors and possible causes. And they had refreshed their knowledge of the need to perform an accuracy check of their own work when they finished assembling prescriptions.

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 resolve. 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 current professional indemnity insurance. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members checked 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

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete regular training to help keep their knowledge and skills up to date. And they feel comfortable raising concerns and making suggestions to improve the way they work.

Inspector's evidence

The pharmacy was staffed by two pharmacists, four pharmacy technicians, three of which were qualified accuracy checking technicians (ACTs), ten dispensers, two of whom were the store manager and deputy manager, and a trainee medicines counter assistant. Team members managed the workload well during the inspection. They completed mandatory e-learning modules regularly, which usually focussed on mandatory compliance training such as information governance, safeguarding and incident management and reporting. But also covered seasonal topics and services. Some recent examples were training to support Covid-19 vaccination service and the NHS contraceptive service. Team members also regularly discussed learning topics informally with each other. The pharmacy had an appraisal process for pharmacy team members. They had a meeting every year with their manager to discuss their performance. And they set objectives to address any learning needs identified. They also had informal discussions with their manager every few weeks to discuss their progress. 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.

Team members explained how they would raise professional concerns with the pharmacist, the store managers and the area manager 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 way they communicated about ordering the stock they required to fulfil prescriptions. This included communicating more clearly and effectively to help prevent over-ordering and wastage, particularly with higher-risk and expensive medicines. The pharmacy had a whistleblowing policy, and pharmacy team members knew how to access this. They were also aware of other organisations where they could raise concerns, such as GPhC and NHS England.

Team members communicated openly during the inspection. They 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. And 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 an adequate space for the services it provides. The pharmacy has a suitable room where pharmacy team members can speak to people privately. And team members adequately prevent unauthorised access to the secure areas of the pharmacy.

Inspector's evidence

The pharmacy's registered premises was within a larger Boots retail store. And there were areas of the registered pharmacy on the ground and first floor. 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 secure premises. It had a consultation room, which was clearly signposted, and pharmacy team members used the room to deliver some services and have private conversations with people.

There were clean, well-maintained sinks in each of the areas of the pharmacy used for medicines preparation. There was 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.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely. And they use the available technology to help them do this effectively. The pharmacy suitably sources its medicines. And it stores and manages its medicines appropriately and securely. The pharmacy's services are easy for people to access. And it has processes to help people understand and manage the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the shopping centre through automatic doors. It had a hearing induction loop, and pharmacy team members explained how they would use the system and communicate in writing with people with a hearing impairment. They could provide large-print labels and instruction sheets to help people with a visual impairment access services.

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 baskets to help prevent prescriptions being mixed up. Team members used the electronic patient medication records (PMR) system barcode scanning technology to help improve the accuracy and safety of their dispensing. Team members demonstrated how they picked medicines from the shelves and scanned the barcodes on the packs. The system blocked any further progression of the prescription if a team member scanned the incorrect medicine. They were unable to proceed until they scanned the correct product. Once prescriptions had been completed and checked by the pharmacist, they scanned the barcode on the bag's label and assigned the bag to a shelf, ready for people to collect or for the pharmacy to deliver. Team members used a handheld device to locate the bag when people arrived at the pharmacy. This helped to reduce the time people waited in the pharmacy, and alerted team members if parts of people's prescriptions were stored in different locations, such as items stored in the fridge or the CD cabinet. Team members were aware of the limitations of the technology. And they explained how they would record a near miss error which was identified by the system after they selected the incorrect product from the shelves.

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 CD and some higher-risk medicines. These alert cards highlighted when the pharmacist's intervention was required, such as a medicine prescribed for the first time or if the medicines were for a child. 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. They recorded when they gave advice to people about the risks of valproate, and they had recently completed an audit to confirm that people had been provided with the necessary information. Team members were aware of the need to dispense valproate in the manufacturers' whole original packs.

The pharmacy supplied medicines for a small number of 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. This was a record of all their medicines and the times of administration. They also recorded this information on their PMR. The pharmacy provided medicines to care and nursing homes in the manufacturers original packaging. Some medicines were accompanied by paper medicines administration records (MAR) sheets for home staff to use to record administration of medicines. The pharmacy also provided MARs to some homes electronically. Team members usually communicated with staff at each home about people's medicines via email. And they saved these emails to help them easily resolve future queries. The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for several other local pharmacies within the same company. 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 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 attempted delivery, 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 fridges 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 stock medicines every thirteen weeks. They highlighted 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 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 to help prepare liquid medicines. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals, handheld devices 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.