General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 69-71 Commercial Street, Rothwell, LEEDS, West Yorkshire, LS26 0AP

Pharmacy reference: 1039701

Type of pharmacy: Community

Date of inspection: 08/05/2024

Pharmacy context

This community pharmacy is in the centre of Rothwell a large town near Leeds. It provides a range of services including dispensing NHS prescriptions, the NHS Pharmacy First service and the NHS hypertension case finding service. The pharmacy supplies medicines to people living in several care homes in the area.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. Team members suitably protect people's confidential information, and they understand their role to help protect vulnerable people. The team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) which provided team members with information to support the safe and effective delivery of its services. Team members accessed the SOPs via an online platform and answered questions to confirm they had read and understood them. The pharmacy manager was alerted to new SOPs and changes made to existing SOPs and monitored the team's reading of them. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. Electronic records of these errors, known as near miss errors, were made after the pharmacist or the accuracy checking pharmacy technician (ACPT) discussed it with the team member involved. The team member involved completed the record and captured the near miss reference number on to the prescription to show the record had been made. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident so they could learn from it. And were aware of the actions taken to prevent such errors from happening. For example, after an incident when a person was handed another person's medication all team members were informed. And they were reminded of the checks to be done at hand-out such as asking the person to confirm their postcode. The team updated the pharmacy's electronic patient medication record to highlight people with similar names.

The pharmacy undertook a regular review of the near miss errors and dispensing incidents. And the outcome was shared with team members who discussed the changes they could make to prevent future errors. A recent review had highlighted a common error was the wrong quantity of medication especially when partial packs of a medication were used. And team members had been advised to carefully count the medication dispensed. The pharmacy had a procedure for handling complaints raised by people using its services. And the company's online platform provided a section on frequently asked questions and details on how people could provide feedback.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. Appropriate records were kept of the supply of unlicensed medicines. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. And had been signed by the pharmacists to show they had read them, understood them and would follow them.

Team members had completed training on the General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacy displayed information on how people's confidential data was protected and it displayed a notice about the fair processing of data. The pharmacy had safeguarding guidance for the team to follow. Team members had completed training relevant to their roles and they understood how to raise a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work very well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services. The team members have some opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist and regular locum pharmacists covered the opening hours. Twice a week two pharmacists worked together to enable them to complete tasks such as the clinical checks of the prescriptions for the care homes. The pharmacy team consisted of one full-time ACPT, one part-time ACPT, three full-time dispensers including the pharmacy manager and two part-time dispensers. To support the pharmacists with the delivery of services, particularly the NHS Pharmacy First service, the pharmacy was recruiting for another dispenser. At the time of the inspection most team members were on duty. Amongst the team members was a dedicated team and manager for the care home service.

The team had experienced an increased workload following the closure of a local Boots pharmacy. Team members worked very well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They held regular meetings and team members could suggest changes to processes or new ideas of working. All team members were trained or being trained on how to undertake key tasks. And team members who usually worked in other areas of the pharmacy such as the care home team helped colleagues in the main dispensary when required. As the number of prescriptions increased team members realised more space was needed for storing completed prescriptions. So, they worked on reducing the volume of medicine stock held in the dispensary which created more shelves space. And moved some tasks such as checking prescriptions returned from the Boots offsite dispensing hub to a room to the rear of the pharmacy. Team members rotated their time between the main dispensary and this room. The team used a communication platform to record information for all team members to be aware of. And the pharmacy manager shared key points from the area meetings they attended with team members.

Team members used company online training modules to keep their knowledge up to date. And they had some protected time at work to complete the training. Team members read the newsletter sent from Boots Professional Standards team that provided information on topics such as new services. In preparation for the launch of the NHS Pharmacy First service the team had received a new set of SOPs. The pharmacists had completed additional training reflecting their specific roles such as assessing the conditions listed within the service. Team members received informal feedback on their performance, and they had opportunities to discuss their development needs with the pharmacy manager. One of the dispensers had taken the opportunity of a one-to-one meeting to discuss the requirements for training to be a pharmacy manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. It has good facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. They used a large room to the rear of the pharmacy for dispensing and checking prescriptions for the care homes service. This room provided plenty of space for the team to work and was away from the distractions of the busy retail area.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room which team members used for private conversations with people and when providing services. And there was a separate, cordoned off area that provided privacy to people receiving their medication as a supervised dose. There was restricted public access to the pharmacy during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly conducts checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most suitable product was supplied. And they knew when to refer requests to the pharmacist. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The NHS Pharmacy First service was popular, and the team had seen many people present at the pharmacy since its launch. The NHS hypertension case finding service was also popular and had resulted in some people with raised blood pressure being referred for further tests.

The pharmacy supplied medicines to several care homes of varying sizes. A separate team led by a full-time dispenser managed the service. And usually started the process three weeks before the start of the care home's next cycle to allow time to order the prescriptions and dispense the medication. Prescription requests sent from the care home teams were processed at a central Boots Hub and sent electronically from the GP team to the pharmacy. Any queries regarding the medication ordered were usually sent to the care home team by email. So, there was an audit trail for the pharmacy team and care home teams to refer to. The pharmacy supplied the medication several days before the start of the next cycle to give the care home team time to check the supply. Team members placed dispensed medication ready for delivery in a dedicated area so it could be checked with the delivery drivers when they came to collect the medicines. And attached CD and fridge stickers to the boxes holding the completed prescriptions to prompt the driver to ask for these medicines. The pharmacy had a cut-off time for deliveries to ensure the drivers could complete their deliveries. But urgent deliveries could be arranged, for example when an antibiotic had been prescribed. The pharmacy provided the care home teams with a direct contact number to the team at the pharmacy that managed the service. And liaised with the care home team regarding issues such as the importance of notifying the pharmacy when a person arrived at the care home or when a person was admitted to hospital.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The prepared doses were stored securely and people's doses separated to reduce the risk of a team member selecting the wrong one. And to help prevent the person receiving the wrong dose. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the new rules requiring valproate to be supplied in the manufacturer's original packaging. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and reported no-one prescribed valproate met the criteria.

The pharmacy sent several prescriptions to the Boots offsite hub pharmacy to be assembled there. Before sending the prescription information, the team processed the prescriptions, and the pharmacist completed a clinical check. Some medicines such as CDs and items the person urgently needed were dispensed at the pharmacy to reduce risk. And to ensure people's medicines were ready when they

needed them. Most dispensed prescriptions from the hub were returned to the pharmacy the following day. They were supplied in a sealed bag with a label attached listing the person's details and information such as missing medicines to be dispensed at the pharmacy. Team members matched any prescriptions dispensed at the pharmacy with prescriptions for the same person sent from the hub. And they used the bar code scanning technology to locate where all the completed prescriptions for a person were held to ensure people received all their medicines.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the ACPT to complete their check. There was also an audit trail on the prescription to capture who had downloaded the electronic prescription, completed the clinical and accuracy checks and handed out the medication. The pharmacy used clear bags to hold dispensed CDs and medicines stored in the fridge so the team, and the person collecting the medication, could check the supply. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. When the medication was for one of the care homes the team informed the care home team of this and of the expected date when the medication would be available. People received a text message from the pharmacy advising them when their prescription was ready to collect. A record of the delivery of medicines to people was kept for the team to refer to when queries arose.

The pharmacy obtained its medication from reputable sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. They checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were clearly marked to prompt the team to check the medicine was still in date. A list of short-dated medicines was kept for the team to refer to each month and remove any medicines that had reached the expiry date. No out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records showed the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And the team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. And fridges to hold medicines requiring storage at these temperatures. The pharmacy regularly completed safety checks on its electrical equipment.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. And some team members wore headphones that enabled them to easily contact colleagues in other areas such as the care home room. They stored completed prescriptions away from public view and they held other private information in the dispensary and rear areas which had restricted public access.

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.