General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 56 High Street, Kippax, LEEDS, West Yorkshire, LS25 7AB

Pharmacy reference: 1039739

Type of pharmacy: Community

Date of inspection: 04/12/2019

Pharmacy context

This community pharmacy is amongst a parade of shops in the large village of Kippax. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service.

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	1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team pro-actively responds when people using the pharmacy services raise concerns.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The pharmacy supports team members who identify areas of practice they wish to develop. So, they can keep their skills and knowledge up-to-date.
		2.5	Good practice	The team members support each other in their day-to-day work. They observe each other's work and provide feedback. So, the team member can reflect on their performance. They feel comfortable to provide feedback on ways of working. So, they can identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team may miss opportunities to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. And the team member involved recorded their error. A sample of the near miss error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. And team members usually recorded what caused the error. But they did not record the actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The pharmacy had labels that asked the team to select and speak the product selected. The labels acted as a prompt for the team to check the medicine selected to help reduce picking errors. The team attached these labels to shelves holding items that looked and sounded alike (LASA). These medicines included amlodipine and amitriptyline. The pharmacy displayed laminate cards next to the computer terminals listing common LASA medicines for the team to refer to. The team had added pregabalin and gabapentin to this list.

The pharmacy undertook a monthly patient safety review. The pharmacy technician led on the review. And shared the results with the team members to discuss what changes to processes they could make to prevent future errors. The pharmacy technician displayed the outcome from the latest review in the dispensary for the team to refer to. The pharmacy technician used a recent review to remind the team to always record changes made to medicines in the multi-compartment compliance packs. So, all team members were aware of the changes when preparing the packs. The team was also reminded to prioritise the dispensing of prescriptions for urgent medicines such as antibiotics. The pharmacy completed an annual patient safety report. The latest report detailed the team introducing an extra check when dispensing CD prescriptions. The team member dispensing the prescription asked another team member to check the CD picked before the pharmacist did the final check. The report also captured that the team members were reminded to ask the person for their postcode as part of the checks made by the team when handing over completed prescriptions. So, the team members could ensure they gave the medicines to the correct person.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And displayed the recent results in the consultation room. Positive comments included the team providing an efficient service. Areas for improvement included the comfort and convenience of the pharmacy and the time taken to process prescriptions. The local GP teams had stopped people using the pharmacy to order their repeat prescriptions. So, people had to order their own prescriptions. The team received several comments about this as people did not like the change. And people were often unhappy with the delay with collecting their prescription. On some occasions the team received verbal abuse about the delays. The team members were managing this by labelling prescriptions as soon as possible after they were sent to the pharmacy. And storing the labelled prescriptions in alphabetical order so they could easily locate them when a person presented at the pharmacy for their prescription. The team also prioritised prescriptions for urgent items such as antibiotics. And provided people with information on the usual processing time for prescriptions from sending in the request to the medicines being ready to collect.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy had a leaflet informing people about the confidential data it kept. And it displayed a notice about the fair processing of data. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to safeguarding information and contact numbers for local safeguarding teams. The pharmacists and ACT had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members had completed Dementia Friends training. And they responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy is good at providing the team members with opportunities to develop their knowledge and skills. The team members support each other in their day-to-day work. They proactively observe each other's work and provide feedback. So, the team member can reflect on their performance. They feel comfortable to provide feedback on ways of working. And they share the learning from mistakes they make during dispensing to support the safe and effective delivery of this pharmacy service.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Boots relief pharmacists provided support when required. Once a week there were two pharmacists on duty. The pharmacy team consisted of a full-time pharmacy pre-registration student, a full-time pharmacy technician who was also an accuracy checking technician (ACT) and six full-time qualified dispensers. One team member was absent from work and another had been sent to support a team at a local store. At the time of the inspection a Boots relief pharmacist, the pre-registration student, the ACT, two dispensers and a Boots relief dispenser were on duty. The pharmacy was training all dispensers to support services such as the supply of multi-compartment compliance packs. So, the service was not affected by absence or if a team member solely responsible for the service stopped working at the pharmacy.

The pharmacy provided extra training through e-learning modules. The pharmacy held morning team meetings to plan the day ahead. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist manager was new to the team and had spent time with each team member to get to know them. One of the dispensers spent a lot of time managing the retail area. And was working with the pharmacist manager and ACT to spend more time in the dispensary. So, they could maintain their dispensing skills. Another member of the team used the opportunity to ask about management training. The team member discussed this with the new manager. And it was arranged for the team member to help with some managerial tasks whilst they waited for a training place to become available. So, they could gain some experience.

The pharmacy had a template for team members to record their observations about each other when they were providing pharmacy services. The template included the advice the team member had given to people using the pharmacy. And the feedback from the colleague observing. Examples included observations of the team member asking appropriate questions of person requesting to buy a medicine. And using the person's electronic medication record (PMR) to confirm details before asking the pharmacist about the sale of a product. The pharmacy displayed a whistleblowing policy for the team to refer to when they wished to raise a concern.

Team members could suggest changes to processes or new ideas of working. The team members identified the processing time for multi-compartment compliance packs was too short. The current timescale did not help the team manage the workload pressure of completing the packs and dealing with any problems. So, the team members were working to get a week ahead with the preparation of the packs. The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was small with limited work space. The team managed this by keeping the work benches free of clutter. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink, disposable gloves and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. And they manage the pharmacy services well. The team members keep records of deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines adequately.

Inspector's evidence

People accessed the pharmacy via a step-free entrance through an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy had up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the flu vaccination. This service was popular with people who commented on the convenience of the service. The pharmacy had adrenaline injections available in case someone had an anaphylactic reaction to the vaccine. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses with the prescription in the controlled drugs cabinet in separate clear bags. This helped to reduce the risk of selecting the wrong one.

The pharmacy provided multi-compartment compliance packs to help around 120 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The processing of the packs resulted in them being ready two days before supply. But the team recognised this was too short a time interval especially if problems arose. The pharmacist manager and ACT were working with the team to get a week ahead. This involved preparing, where possible, packs to cover five weeks. So, in January 2020 the team would be one week ahead. The team ordered prescriptions in advance before supply. Each person had a medication record listing their current medication, dosage and dose times. The medication record included information such as the day of the week people took medicines if prescribed to be taken once a week. The team checked received prescriptions against the medication record. And queried any changes with the GP team. The pharmacy received prescriptions one week at a time. To manage the workload the team dispensed packs for four weeks together against the first prescription. The team copied the first prescription, wrote copy on to the prescription, and then attached it to each completed pack awaiting the weekly prescription. The packs had a clinical and accuracy check at this point and a second check when the prescription arrived at the pharmacy. The second check included reference to the copy of the first prescription and the weekly prescription sent to the pharmacy. The team kept the empty containers the medicines were removed from for the pharmacist or ACT to refer to when checking the packs. The team used a small room at the rear of the pharmacy to dispense the medication. This was away from the distractions of the retail area. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets.

The team stored completed packs in box files labelled with the person’s name and address. And stored the box files on shelves divided across the days of the week. The pharmacy had a collection document

for the team members to record when they had supplied the packs. The team recorded details such as the date of handing the packs out. And obtained a signature from the person collecting the packs. The team referred to this when queries arose. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. The team displayed a list of people admitted to hospital so everyone knew this, and packs would not be sent to the person. The team used a communication book to capture information such as changes to people's medicines. So, all the team were aware and could update the medication record.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used trays when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves and used this as a prompt to check what they had picked. The pharmacy team used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person obtained from the electronic medication record (PMR) during labelling. These forms included dose changes or new medication. The PIF stayed with the prescription until the team supplied the medication. So, everyone could refer to the information captured on the PIF. The team used the PIF to record medicines that looked and sounded alike (LASAs), as these were often linked to errors. This acted as an additional prompt for the team to check the medicine that had been dispensed.

The dispensers labelled prescriptions and placed them in trays labelled with the day of the week this was done. The prescriptions were kept in alphabetical order. So, if the person came in to collect their prescription the team could easily find it. The pharmacist clinically checked the labelled prescriptions before passing them back for the dispensers to dispense them. The team placed the dispensed prescriptions on dedicated shelves awaiting the accuracy check by the pharmacist or ACT. The team used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person. For example, their latest blood test results. And the team recorded this information on to the electronic patient record (PMR). The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. And the team members used the PMR to record when they identified a person meeting the criteria.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a quad stamp. The pharmacy used this as an audit trail of who had clinically checked, accuracy checked, dispensed and handed out the medication. When the pharmacy didn’t have enough stock of someone’s medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 03 November 2019. The team used a caution short-dated stock sticker with the expiry date written on to highlight medicines with a short expiry date. And it kept a list of products due to expire

each month. No out of date stock was found. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team members used a separate record to capture they actions they had taken and the follow-up temperature readings when the first reading of the day was outside the normal range. So, they could show that the fridge was at the correct temperature. The team members did not always record the date of opening on liquids. So, they may not identify products with a short shelf life once opened. And check they were safe to supply. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team did not have a date when the pharmacy would have the equipment installed. The pharmacy obtained medication from several reputable sources. And 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 mostly protects 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 clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. And the team locked the computer screen in the consultation room when it was not in use. The pharmacy mostly stored completed prescriptions away from public view. But the end section of the retrieval area was close to the pharmacy counter and the area where people waited. People standing close to this section could read the bag labels with people's names and addresses printed on. The pharmacy held other private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.