General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 6-8 Middleton Park Circus, Middleton, LEEDS, West Yorkshire, LS10 4LU

Pharmacy reference: 1039775

Type of pharmacy: Community

Date of inspection: 21/01/2020

Pharmacy context

This community pharmacy is amongst a parade of shops in a large suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And the supervised methadone consumption service. The pharmacy provides the Community Pharmacist Consultation Service (CPCS).

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	2.5	Good practice	The team members discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members 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	4.1	Good practice	The team reaches out to the local community to promote pharmacy services such as the flu vaccination service. The team proactively interacts with other organisations to understand the support the other organisations give to people. And the team shares this knowledge with people using the pharmacy to help improve their health and well being. The team members spend time with people to identify the help they may need to take their medicines safely. And they provide a range of devices to support people to safely take their medicines.
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. The pharmacy team members respond well when errors happen. They take the appropriate action to help prevent similar errors happening again. And they make effective use of the tools available to review these errors. So, they can improve the safety and quality of the pharmacy services. People using the pharmacy can raise concerns and provide feedback. 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 keeps most of the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date 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 SOPs described the roles and responsibilities of the team. And each SOP listed the team members the SOP related to. The team had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. The team members understood their role and worked within the scope of their role. And they would refer queries from people to the pharmacist when necessary. 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. Each team member had their own near miss record. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error and the actions they had taken to prevent the error happening again. The pharmacy completed an electronic report for dispensing errors. These were errors identified after the person had received their medicines. The pharmacy sent the report to head office. And printed it off for reference in case of queries. The pharmacy had trained all the team to complete the report to ensure it was done in a timely manner. The pharmacist informed all the dispensary team of any dispensing incidents. The team discussed a recent dispensing incident when a person prescribed two different formulations of a medicine received only one version. The team members identified that having two formulations of the medicine was unusual. So, the team members were reminded to double check the medicines dispensed against the prescription when dispensing and checking.

The pharmacy undertook a monthly patient safety review. The pharmacy technician led on this and shared the results with the team members. The pharmacy technician displayed the outcome from the latest review in the dispensary for the team to refer to. The team attached notes about near miss errors and other patient safety incidents to the template for the next review. So, the information was to hand when the pharmacy technician completed the review. The pharmacy had recently upgraded the computer system. This had resulted in a change to the dispensing procedure. This included the team scanning the bar code on the dispensed product to see if it matched the prescription. The team noticed since the introduction of this process the number of picking errors had reduced. The pharmacist asked the team in light of the reduction in picking errors to remain focused on other patient safety incidents. So, the patient safety review remained an active tool for improving patient safety and team

effectiveness. For example, recent reviews reminded the team to use the quad stamp to show who had completed the different steps in the dispensing and prescriptions. Another review highlighted to the team to take care with children's medicines. And to take care with medicines that looked alike and sounded alike (LASA) such as pregabalin and gabapentin. The pharmacy displayed laminate cards next to the computer terminals listing the LASA medicines for the team to refer to.

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. The team used the same system that they recorded dispensing incidents to capture people's complaints about the supply of medicines. For example, when a person was unhappy that the pharmacist refused to sell them a medicine because it was not appropriate to do so.

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. Records of emergency supply requests met legal requirements. A sample of records of private prescription supplies found that the prescriber's details were not always correct. A sample of records for the receipt and supply of unlicensed products looked at found that most records met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulation (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 had safeguarding guidance and team members had access to contact numbers for local safeguarding teams. The pharmacist manager had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team 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 provides team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. So, they can keep their skills and knowledge up-to-date. The pharmacy supports an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. They discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Boots relief pharmacists covered the other hours. The pharmacy team consisted of a part-time pharmacy technician, a full-time pharmacy technician currently employed as a pharmacy assistant and two part-time pharmacy assistants. At the time of the inspection the pharmacist manager and the pharmacy technician working as a pharmacy assistant were on duty. The team was supported by a pharmacy pre-registration student who had completed their training and was waiting to take the exam, so was working as a Boots relief dispenser. There was also a student from a local school on work experience. The school student was putting stock such as toiletry products away on the shelves in the retail area. The team members left notes for each other with information to share or tasks to be completed. And they used a diary to record information such as when a person's prescription was ready to collect. They worked well together to manage the workload.

The pharmacy provided extra training through e-learning modules. The team members read the publication sent from Boots Professional Standards team and signed it once they had read it. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist manager provided informal feedback to team members as part of the team meetings. 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. 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 discussed with the pharmacist manager concerns they had about working all day in the front section of the dispensary. The team used this section of the dispensary to dispense walk-in prescriptions and hand out prescriptions. This section was also used by people asking for advice or to buy over-the-counter medicines. The team members identified that long periods of time in this section led to tiredness and a risk they may lose their concentration. The pharmacist manager agreed for the team to rotate between the front and rear areas of the dispensary. And asked the team members to schedule amongst themselves each morning who was going to work in each section. Two team members introduced a three-way check when dispensing repeat prescriptions. When the stock arrived for the prescriptions one dispenser placed the stock and the prescription together in a tub. The second dispenser generated the labels and scanned the products to check they matched the prescription before passing it back to the first dispenser to attach the labels. The two introduced this to provide opportunities to spot errors

before the pharmacist completed their final accuracy check. The pharmacy had some targets for the business side of the pharmacy and for some of the services provided. 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 adequate for the services provided. The team manages the limited work space well. 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 upgraded computer system had helped the team reduce the volume of stock held. This had created more space in the storage drawers. The team members were rearranging the medicines, so they were not tightly packed together to help reduce picking errors. The pharmacist manager was also using the space on the shelves to store the manufacturers information leaflets. So, they were available for the team to hand over to the person when required.

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's service are accessible. The team members reach out into the local community to promote the pharmacy's services. And they share the knowledge they gain of other services available in the community with people accessing the pharmacy. So, they can support people's health needs. The team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them. The pharmacy 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 appropriately.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy had a temporary ramp for the team to use to help people enter the pharmacy. 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 seasonal flu vaccination service had been popular. People commented on the convenience of the service. The team supported the delivery of the service by identifying people who would benefit from receiving the vaccination. And highlighting them to the pharmacist. The pharmacist and pharmacy technician used a local newsletter to promote the flu vaccination service. And they had attended an event at a local club for older people. The pharmacist had taken the opportunity to ask for an updated list of the events ran at the club. So, they could pass this information on to people. The pharmacy technician volunteered at the Charlies-Angel-Centre foundation providing bereavement support for parents and families. So, they could share the information from this organisation with people. The Community Pharmacist Consultation Service (CPCS) service was popular. The pharmacist gave feedback to the NHS 111 service about incorrect CPCS referrals. So, the team at NHS 111 was aware and could monitor the number of incorrect referrals made.

The pharmacy provided multi-compartment compliance packs to help around seven people take their medicines. The team had transferred the preparation of several packs to two other Boots. But these two Boots pharmacies had reached their limit on providing this service. Before accepting new people on to the service, the pharmacist manager took the opportunity to assess the person’s need for the service. And spent time with the person to see what support they required to help them manage their own medicines. The team ordered a range of compliance packs to offer people. And discussed with the person how to use the packs. The team also provided the person with a medicine chart that included the medicine dose times. So, they knew when to take their medicines. And they could mark the chart to know they had taken the medicine.

To manage the workload of preparing the packs the pharmacy provided to people the team usually ordered the next batch of repeat prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. But some prescriptions were only released on the day of supply. The team managed this by dispensing the medicines from the prescriptions at the pharmacy in to the packs. And marking the pack to show what items were to follow. The team prioritised the completion of the pack when the prescription arrived. The pharmacist manager had spoken to the GP teams about changing

the release date so the team could have the prescription a few days before supply. But this had not happened. Each person had a medication record listing their current medication, dosage and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. 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 kept a record of the packs sent from the other Boots pharmacies in case queries arose.

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 in a dedicated controlled drugs cabinet on shelves marked with day of supply. The pharmacist attached the prescription to the dose due, to help reduce the risk of selecting the wrong one. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacist had spoken to the one person who met the criteria to ensure they were on a PPP and to give appropriate advice to the person. The pharmacist kept the PPP information leaflets with the valproate stock to supply to people when required.

The team members provided a limited repeat prescription ordering service. Several GP surgeries had stopped the pharmacy teams from ordering people's prescriptions. The person had to order their own prescription directly with the GP surgery. The team asked people to order their prescription one week before they needed the supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team used a diary to record information about a person's prescription such as those collected from the GP surgery. The team downloaded the electronic (EPS) prescriptions in batches. The team accessed each person electronic medication record (PMR) to process the prescription and to check the PMR for any information about the person such as a preferred brand of medicine. This process generated an order of the medicines on the prescription. The team placed all the processed prescriptions into a basket awaiting the delivery of the medicines from the wholesaler. And used a section of the dispensary to hold the medicine stock when it arrived. Each prescription was matched with the stock ordered and placed in to a tub. The team then labelled the prescription and attached the labels. The team members used the bar codes on the prescription and the products to check they had dispensed the correct medicines. The team also checked the details on the dispensing label with the prescription. A recent patient safety report had reminded the team to ensure stock orders were sent after processing the prescription. So, all the medicines were available at the point of dispensing the prescription. The team members were also reminded to check the system after processing each prescription to see if there was another prescription for the person. And to ensure they kept EPS prescriptions together. To reduce the risk of a person not receiving their full supply of medicines. The team provided some people's medicines as weekly supplies. The team used baskets to hold the prescription and the medicine stock so they could provide the medicine without delay.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets 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. The team members 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 that was obtained from the PMR during labelling. These forms included dose changes or new medication. The team also used alert cards for products such as warfarin to prompt the pharmacist to ask for information from the person and provide advice. For example, their latest blood test results. And the

team recorded this information when it was given. 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.

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 laminate cards on bags and prescriptions to remind the pharmacist when checking prescriptions and the team when handing over medication to include these items. The pharmacist reminded the team to place these laminate cards in the baskets at the point of picking the stock. So, medicines such as fridge items were not missed. 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 pharmacist manager used recent patient safety reviews to remind the team to keep the PIFs with prescriptions that had owings. So, the team could refer to the information captured on the PIF up to the point of supply. 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 12 January 2020. The team attached a 'caution short dated stock' sticker to the packaging 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 members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 18 January 2020 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. 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 scanning equipment installed to meet the requirements of the Falsified Medicines Directive (FMD). But it was waiting for a computer upgrade to enable the team to scan FMD compliant packs. 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 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 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 pharmacy completed safety checks on the electrical equipment.

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. The pharmacy stored completed prescriptions away from public view. And it held 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.