General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 11 New Road Side, Rawdon, LEEDS, West Yorkshire, LS19 6DD

Pharmacy reference: 1039785

Type of pharmacy: Community

Date of inspection: 17/01/2023

Pharmacy context

This community pharmacy is next door to a medical centre in Rawdon. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. And it supplies some people with their medication in multi-compartment compliance packs to help them take their medication. The pharmacy provides the seasonal flu vaccination service and the NHS hypertension case finding 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	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 written procedures that the pharmacy team follows. And it completes the records it needs to by law. The pharmacy protects people's private information correctly and it provides the team members with training and guidance to help them respond to safeguarding concerns. Team members respond appropriately when errors happen, they identify what caused the error and they act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) which were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. Team members accessed the SOPs and answered a few questions to confirm they had read and understood them, which was monitored by the pharmacy manager. They received notification of new SOPs or when changes were made to existing SOPs, and they had protected time at work to read them. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure to record and learn from errors made during the dispensing process known as near misses. The pharmacist when checking a prescription and spotting an error usually discussed it with the team member involved who recorded the error on to an electronic platform. The pharmacy completed electronic records of errors that were identified after the person received their medicines, known as dispensing incidents. The team sent them to the head office team. The pharmacy technician regularly reviewed the near miss errors and dispensing incidents. And they shared the outcome from the review with team members, who discussed the changes they could make to prevent future errors. A recent review resulted in a reminder to the team to ensure glyceryl trinitrate sprays were correctly labelled. Following a hand-out error when someone received another person's medication the team was reminded of the process to follow including confirming the person's details. And a pop-up note was created on each person's electronic record which alerted the team to the similarity of the two people's details. The team had used the learning from this error to check for other people with similar names and addresses and added pop-up notes to their records when necessary. A list of common medicines that looked and sounded alike (LASA) was displayed next to the computer terminals for the team to refer to.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And leaflets in the retail area provided people with information on how to raise a concern with the pharmacy team. The pharmacy manager monitored feedback left on social media platforms to identify any areas of concern. And to advise the team when positive feedback was given.

The pharmacy had up-to-date 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 pharmacy completed regular checks of the balance of the CD registers to identify errors or missed entries. It had a leaflet informing people how their confidential data was protected and it displayed a notice about the fair processing of data. Team members had completed training on the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy provided the team with safeguarding training and guidance. And the pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Team members were aware of the actions to take when a safeguarding matter arose but they'd not had the occasion to report such concerns.

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. Team members benefit from identifying areas of their own practice they wish to develop and the pharmacy supports them with ongoing training to advance their skills and knowledge.

Inspector's evidence

A full-time pharmacist and part-time pharmacist covered the pharmacy's opening hours. The pharmacy team consisted of a full-time pharmacy manager who was a qualified dispenser, a full-time pharmacy technician, a full-time dispenser and two part-time dispensers. The pharmacy technician supported the pharmacist with tasks such as checking the CD balances in the CD registers. The pharmacy had faced some recent staffing challenges and the team was catching-up with workload from the Christmas period. This had led to a few tasks not being fully completed such as putting away the medicine stock received from the wholesaler. The team members worked very well together and supported each other particularly to ensure people presenting at the pharmacy counter were not kept waiting.

Team members used company online training modules to keep their knowledge up to date and they had protected time to complete the training. The manager monitored the team's completion of the training and offered support when required. The pharmacy provided formal performance reviews to team members to give them a chance to receive individual feedback and discuss their development needs. And they were given informal feedback when appropriate. The pharmacy technician had used the opportunity to discuss training to be a vaccinator to support the following year's flu vaccination service.

The pharmacy frequently held meetings which enabled team members to discuss their workload and plan how to manage it. And they could suggest changes to processes or new ideas of working. The pharmacy manager had reviewed the process for the new medicines service and introduced steps to ensure it was done correctly. This helped to ensure everyone who would benefit from the service was identified and offered the service. In addition to the communications book and diary team members used an online communication tool to share key pieces of information. This ensured all team members were kept-up-to date with relevant information and could refer to the details from previous communications when required.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were hygienic with separate sinks for the preparation of medicines and hand washing. And hand sanitising gel for the team to use. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. The dispensary was small with limited bench space for the team members to work from. They generally managed the limited space well but occasionally some baskets were piled on top of each other, creating an increased risk of errors. Several tote boxes containing medicines delivered by the wholesalers were stored on top of each other. The team moved the boxes to reduce the risk of tripping over them, but this limited the team's access to the pharmacy sink and some storage areas.

The pharmacy had a large, soundproof consultation room that was locked when not in use. The room was used for private conversations with people and for providing services such as flu vaccinations. And it had a sink and alcohol gel. The pharmacy restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. And it manages its services well to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from reputable sources, and it suitably stores and manages its medicines.

Inspector's evidence

People accessed the pharmacy via an automatic door that was operated with a press pad. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. Team members provided people with information on how to access other healthcare services when required. And they wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They provided people with clear advice on how to use their medicines and they asked appropriate questions when selling over-the-counter products. They used alert cards for higher-risk medicines to prompt the pharmacist to ask for information from the person such as their latest blood test results. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And they regularly reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. Information such as a new medicine or a dose change was kept with the prescription. So, the pharmacist was aware and it prompted the team to discuss the information with the person when handing over their medication. One of the dispensers involved the pharmacist in a conversation with a person about the use of inhalers to treat asthma and how to access an asthma action plan.

The team had a good working relationship with the team in the medical centre and received regular referrals to the NHS community pharmacist consultation service. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to administer the vaccine. Up-to-date adrenaline pens were available in the consultation room for the pharmacist to use in the event of a person having an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 12 people take their medicines. The pharmacy reviewed people who received packs to ensure this support remained suitable for the person’s needs. Due to the limited space in the pharmacy and an increased workload the team referred people asking for the service to local pharmacies that provided the service. To manage the workload the team usually started the processing of the packs one week before supply to allow time to deal with issues such as items missing from the prescriptions. Each person had a record listing their current medication and dose times which was referred to during the dispensing and checking of the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy occasionally received copies of hospital discharge summaries which the team checked for changes or new items.

The team used baskets during the dispensing process to isolate individual people’s medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. And a sample found the team completed both boxes. The pharmacy also had a quad stamp to capture who had

clinically checked, accuracy checked, dispensed and handed out the medication. 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. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The team stored completed prescriptions neatly on dedicated shelves. And scanned the prescriptions into a particular area on the shelves using a barcode attached to the shelf. When the person came to collect their prescription, the team used the barcode scanning to identify where the prescription was held and to check the correct prescription had been picked. Team members sent people a text message to advise them when their prescription was ready to collect. They kept a record of the delivery of medicines to people and contacted them to advise them of a failed delivery.

The pharmacy obtained medication from several reputable sources and the team followed the pharmacy's procedures to ensure medicines were safe to supply. This included marking medicines with a short expiry date to prompt them to check the medicine was still in date. And recording the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines remained safe to use. The team checked and recorded fridge temperatures daily and a sample of completed records found the readings were within the correct range. The pharmacy securely stored CDs in a cabinet that met legal requirements. And it had medicinal waste bins to store out-of-date stock and patient returned medication. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Team members 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 its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And a blood pressure monitor that was regularly checked to ensure it gave accurate readings. The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used cordless telephones to ensure conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary 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.