General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 6A, Forster Square Retail Park, BRADFORD, West Yorkshire, BD1 4AG

Pharmacy reference: 1088115

Type of pharmacy: Community

Date of inspection: 18/04/2024

Pharmacy context

The pharmacy is in a retail park in Bradford city centre. 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. The pharmacy delivers medicines to people's homes.

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 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 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. Pharmacy 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 men to manage the risks of taking sodium valproate.

The pharmacy provided the NHS Pharmacy First service 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 room to deliver the service from. And ensuring they had stock of the relevant medicines and the availability of the necessary equipment. They also ensured they had completed the necessary training and whether the pharmacy had the correct SOPs and supporting documents in place. This included preparing team members to be able to manage people's expectations of the service and what treatments the pharmacy could provide, and for whom. The pharmacy had a guide for team members to refer to, to help them manage people's requests and to collect key information before passing them to the pharmacist for assessment. The guide also clearly provided information about the signs of sepsis for the team to be aware of when speaking to people. Team members explained they felt confident providing the service for people. And they were clear about the services limitations and when to refer someone to the pharmacist.

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. They used an electronic system to record their mistakes. And the data collected 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 this information in most records to help inform the analysis process. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. But during the inspection, the records of errors could not be accessed because the store manager was not available. So, the quality of error recording could not be assessed. The pharmacy's patient safety champion analysed all data collected about near

miss and dispensing errors each month to help identify patterns. Team members discussed the patterns found at a monthly meeting and implemented changes to help prevent the same or similar errors happening again. A recent example had been a pattern of errors being caused by distractions when people were dispensing. To help address this, team members had made several changes to their working pattern to help manage distractions more effectively.

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 audited 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 a regular pharmacist and three dispensers, one of which was also the assistant store manager. 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 they 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.

A team member 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 prepared and dispensed prescriptions while team members were absent on a lunch break. This included leaving repeat prescriptions until team members returned from their breaks to help reduce the risks of mistakes caused by distractions. The pharmacy had a whistleblowing policy, and pharmacy team members knew how to access this.

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 mostly 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. The pharmacy was open for longer that the retail store for an hour per day, six days a week. When the store was closed, the pharmacy provided services to people via a secure hatch at the front of the building. The pharmacy was clean and mostly well maintained, except for a retractable tape barrier which was broken and had been reported several times. 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 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.

The store also had a warehouse that was mostly not part of the pharmacy's registered premises. The pharmacy stored some surplus pharmacy-only (P) medicines and confidential documents in a locked cage in the warehouse, which only pharmacy team members had access to. And the cage was included in the pharmacy's registered area. There was a clean, well-maintained sink in 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 retail park through automatic doors. The pharmacy 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. The pharmacy had a secure hatch at the front of the store where it provided people with services when the store was closed, and the pharmacy remained open.

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 through the system 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 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 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 fridge 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 and recorded 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.