General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2 Corton Wood, Brampton, BARNSLEY, South Yorkshire, S73 0TB

Pharmacy reference: 1088678

Type of pharmacy: Community

Date of inspection: 08/02/2023

Pharmacy context

This community pharmacy is on a retail park between Barnsley and Rotherham in South Yorkshire. The pharmacy forms part of a larger Boots store. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy offers a seasonal flu and pneumonia vaccination service for people. And it has also provided a COVID-19 vaccination service throughout the recent pandemic.

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	The pharmacy clearly advertises how people can provide feedback about its services. And it uses this feedback to inform change. It monitors these changes to ensure they are working effectively.
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 risks associated with providing its services well. It keeps the records it needs to by law up to date. And it keeps people's confidential information secure. The pharmacy advertises how people can provide feedback about its services clearly. And it uses the feedback it receives to help inform and monitor change. Pharmacy team members understand how to recognise and raise concerns to help safeguard vulnerable people. They behave openly and honestly by engaging in processes designed to share learning following mistakes. And they take appropriate steps to reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had a comprehensive range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. The company was in the process of making its SOPs available to team members via an electronic portal. An up-to-date contents section within the SOP folder informed team members whether the most recent version was available as a hard copy or electronically. A sample of training records demonstrated that team members engaged in regular learning that assessed their understanding of the SOPs. And there was monitoring processes to ensure this learning took place in a timely manner. Pharmacy team members had a good understanding of their roles and responsibilities. They were observed working in accordance with both dispensing and sales of medicines SOPs. And they engaged positively in the inspection process when demonstrating their working processes. The responsible pharmacist (RP) on duty was a locum pharmacist. They were required to keep their own learning associated with the company's SOPs and pharmacy's services up to date.

Pharmacy team members engaged in learning following mistakes made and identified during the dispensing process, known as near misses. This learning involved team members correcting their own mistakes, discussing them, and recording them on an electronic near miss record. The team also recorded mistakes that were identified following the supply of a medicine to a person, known as a dispensing error. There was evidence of continual learning following mistakes through engagement in monthly patient safety reviews. And team members demonstrated the actions they took to reduce risk during the dispensing process. For example, team members scanned the barcode of the medicines they picked during the dispensing process and addressed warning prompts on the patient medication record (PMR) system appropriately. They annotated prescriptions clearly when barcodes would not scan to inform pharmacists of the need for increased vigilance due to the extra manual input into the dispensing process.

The pharmacy advertised how people could provide feedback and raise a concern. And its team members had a clear understanding of how to manage feedback and escalate concerns to the manager or to the company's customer care team. The team provided examples of how feedback from people using the pharmacy's services was used to inform improvement. For example, the team had created an 'awaiting stock' shelf in the dispensary to help it manage owed medicines, and to ensure it kept people up to date with the status of their prescription. This included telephoning people when medicines were out of stock to discuss the options available to them. The team had monitored the change to ensure it was working effectively. Pharmacy team members engaged in safeguarding learning to help protect vulnerable people. And they had recently completed refresher training associated with the 'Ask for ANI'

safety initiative, designed to protect people suffering domestic abuse. Team members on duty were knowledgeable about how to recognise and report safeguarding concerns.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated bags. The team sealed these bags and sent them for secure disposal at regular intervals. All team members engaged in mandatory learning relating to confidentiality and data security. The pharmacy had up-to-date indemnity insurance. The RP notice was displayed prominently and contained the correct details of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy generally kept the records required by law in good order. The pharmacy maintained running balances in the controlled drug (CD) register. But the team did not always record the address of the wholesaler when entering a CD into the register. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team of dedicated and suitably skilled people, who provide its services safely and effectively. Pharmacy team members engage in regular learning relevant to their role. They work well as a team by engaging in ongoing discussions and act with care to reduce risk following mistakes. And they understand how to raise and escalate concerns at work.

Inspector's evidence

The RP was a locum pharmacist who was familiar with the pharmacy. They were working alongside two pharmacy advisors (qualified dispensers). The pharmacy employed two regular part-time pharmacists and it used regular locums and relief pharmacists to cover two days a week. It also employed another pharmacy advisor, and the store manager was also a qualified pharmacy advisor and was observed supporting the team. The pharmacy employed a second pharmacist on days when the vaccination pods were in operation. This allowed one pharmacist to concentrate solely on vaccination services. A team member from the wider store team had completed learning associated with these services and worked as a vaccination assistant, supporting reception and administration processes. The team reported that it sought support from the area relief team to help cover both planned and unplanned absences. Workload was up to date and pharmacy team members were observed working well together.

Pharmacy team members completed regular learning associated with their roles. They engaged in an appraisal process to support them with their learning and development needs. Pharmacy team members understood how to raise a concern at work. And they knew how to escalate a concern if needed. There was an employee support service advertised to team members. This provided them with the opportunity to discuss worries or concerns confidentially. Pharmacy team members shared information continually through both formal and informal processes. These processes included sharing learning through the monthly patient safety review. And day-to-day discussions in the team focussed on managing acute risks and workload. Team members were complimentary of the support they gave each other and of the support they received from their manager and pharmacists. The manager provided details of targets in place to support the delivery of pharmacy services and did not feel there was undue pressure on the team to meet these targets. The RP on duty was not asked to meet specific targets and explained how they worked effectively with team members to support the provision of the pharmacy's services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and adequately maintained. Pharmacy team members understood how to report maintenance concerns and there were no outstanding concerns reported. The pharmacy was clean and floor spaces were free of trip and fall hazards. Air conditioning was provided at store level and the temperature was comfortable. Lighting throughout the premises was sufficient. Pharmacy team members had access to sinks equipped with antibacterial hand wash, sanitiser gel and paper towels.

The pharmacy layout included the healthcare counter and dispensary, a good size consultation room, and an area of the shop floor which had been converted during the COVID-19 pandemic to support the COVID-19 vaccination service. This area was fitted with vaccination pods and was suitably screened from the rest of the store. Office space and an allocated area of the pharmacy's warehouse were also part of the registered premises. The dispensary was fitted with suitably equipped workstations to support the dispensing process, and these were kept clean and tidy between dispensing tasks. The pharmacy's consultation room was clearly advertised and available for use when people requested a quiet conversation with a team member. The room was clean and professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are fully accessible to people. It obtains its medicines from reputable sources. And it stores them safely and securely. Pharmacy team members regularly engage people in conversations about their health and their medicines. And they provide appropriate information to people when supplying medicines.

Inspector's evidence

People accessed the pharmacy through automatic doors from the onsite car park. Details of the pharmacy's opening hours were clearly advertised alongside the stores longer opening hours within window displays. The pharmacy provided seating for people wishing to wait for their medicine or for a service. Additional seating was available when vaccination services were operating. Pharmacy team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine.

Pharmacists had access to up-to-date patient group directions (PGDs) to support the safe delivery of vaccination services. SOPs and supportive information relating to the services were also available to hand. The pharmacy team was able to manage bookings for the vaccination services by opening appointments on the online booking systems. This allowed the team to plan workload and organise a second pharmacist on days when the vaccination pods were in use. The team was adjusting to a new process for recording information associated with the NHS New Medicines Service (NMS). Team members had recently completed learning associated with the process and they discussed the importance of checking the electronic NMS schedule daily alongside the manual schedule which was being phased out. The RP reflected on the delivery of the NMS services and provided an example of how the service had opened up a wider conversation about a person's medication regimen which identified the need for intervention. The pharmacy supplied a small number of medicines in multi-compartment compliance packs. There were no assembled compliance packs awaiting collection or delivery on the day of inspection. A team member demonstrated records associated with the service. And they discussed how the service was provided. This included completing dispensing audit trails to identify who had been involved in the dispensing of the compliance packs. And issuing patient information leaflets when supplying medicines in this way.

The pharmacy held its Pharmacy (P) medicines behind the healthcare counter. This allowed pharmacists to supervise requests for these medicines. Team members were observed providing appropriate advice and information to people when selling medicines. And they referred people to the RP when required. A team member demonstrated how a regular pharmacist had put together resources to support the team in managing requests for specific medicines such as over-the-counter hormone replacement therapy. The folder contained guides for team members to support them in a range of scenarios from first-time requests to repeat requests. A team member using the resources appropriately referred a request to the pharmacist during the inspection. Team members were knowledgeable about the types of medicines which may be liable to abuse, misuse or overuse. And discussed how they would offer opiate advice cards to people when selling medicines such as co-codamol. They regularly shared information with each other about repeat requests for these medicines. And they referred requests to the attention of a pharmacist if they had safety concerns.

The pharmacy had a range of tools to support its team members in identifying higher-risk medicines. This included flags on the PMR system and the use of bright alert cards. The alert cards prompted a series of checks during the dispensing process. Information on the back of the cards supported team members in providing counselling when handing out these medicines to people. But the team did not always take the opportunity to record counselling notes on people's medication records. Pharmacy team members were familiar with most requirements associated with the valproate Pregnancy Prevention Programme (PPP). They were not aware of any recent dispensing of valproate to a person within the at-risk group. Information to support compliance with the PPP was available to hand. A discussion highlighted how the packaging design of branded valproate products assisted pharmacy teams in dispensing the medicine safely.

The PMR generated a 'pharmacist information form' (PIF). PIFs contained key information about each prescription such as dose changes and new medicines. And pharmacy team members could add more information to the PIF to bring information to the attention of pharmacists. The pharmacy team also used alert cards and stickers to prompt additional checks of medicines requiring cold storage, and CDs. This included checking the pharmacy supplied a prescription calling for a CD within 28 days of the date of prescribing. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They also completed an audit trail on prescription forms to identify the person completing the labelling stage, the picking and assembly stage, the clinical check of the prescription, the final accuracy check, and the handout process. The team used barcode technology when transferring bags of assembled medicines waiting to be collected to shelves. This allowed team members to locate people's medicines efficiently when they attended to collect them. Team members were observed checking information on the PMR with people and against bag labels and prescriptions forms when handing out bags of assembled medicines. The pharmacy had efficient processes for managing medicines it owed to people. It kept original prescriptions and used these throughout the dispensing process when managing owed medicines. And it completed regular checks with wholesalers when medicines were out of stock to help it obtain medicines prior to a person running out. The pharmacy had a holding area for medicines waiting to be delivered to people's homes. This was an extra service that people could pay for. The team sent a text to people to let them know when medicines were ready for delivery, people then called the pharmacy to arrange delivery at a time convenient to them.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in their original packaging in an orderly manner. The pharmacy stored CDs in a secure cabinet and storage of medicines within the cabinet was organised. The pharmacy had three medical fridges and it held medicines inside each fridge an orderly manner. It generally monitored the fridge temperatures daily (Monday-Saturday). The team had identified gaps in monitoring of the fridges within the vaccination pod area between clinics. And it had worked to address this issue by placing reminders about the importance of these checks within its 'pharmacist duty folder.' The reminders had worked effectively to manage the issue. Records showed the fridges were operating within the accepted temperature range of two and eight degrees Celsius.

The pharmacy kept records of the date checking tasks conducted by team members. These showed that the team was up to date with its checks. A random check of dispensary stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste and these were stored appropriately. It received medicine alerts electronically, the store manager cascaded details of alerts to the team on a daily basis. And there was an audit trail in place to confirm alerts were checked and actioned in a timely

manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to a wide range of electronic reference resources through a subscription service. They could also access information resources via the intranet, internet, and a designated telephone support line. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines safely and details on bag labels and prescription forms could not be read from the public area. Pharmacy team members used a cordless telephone handset when speaking to people over the telephone. They moved out of earshot of the public area when the phone call required privacy.

The pharmacy team used a range of equipment to support it in delivering the pharmacy's services. This included appropriate equipment for counting and measuring medicines with separate equipment indicated for use when counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Pharmacy professionals providing vaccination services had access to appropriate equipment and resources to support the safe provision of these services. The pharmacy maintained its equipment to help ensure it remained safe to use and fit for purpose. For example, electrical equipment was annotated with information relating to periodic safety testing.

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.