General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Spa Pool Road, Askern, DONCASTER, South Yorkshire, DN6 0HZ

Pharmacy reference: 1095621

Type of pharmacy: Community

Date of inspection: 12/03/2024

Pharmacy context

This community pharmacy is in a health centre in the town of Askern, South Yorkshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides the NHS England Pharmacy First service that supports people with access to consultations and treatment for a range of minor conditions.

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	1.2	Good practice	Pharmacy team members participate in a series of monitoring checks to support the safe and effective running of the pharmacy. They act to reduce risk following the mistakes they make during the dispensing process. And they keep the actions they take under review to ensure they remain effective.
2. Staff	Standards met	2.2	Good practice	The pharmacy actively encourages its team members to develop their skills through training aligned to their roles. Its team members clearly demonstrate how they use the knowledge they gain to support them in delivering the pharmacy's services safely.
		2.5	Good practice	Pharmacy team members are empowered to provide feedback and raise concerns. And the pharmacy uses this feedback to inform the way it provides its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy team members keep effective records of the conversations they have with people to support them in taking their medicines properly. Team members engage in regular audits and learning to support them in supplying higher-risk medicines safely.
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 to its services well. It completes a range of checks to monitor the services it provides. And it shares the outcome of these checks with its team members to support them in working safely and effectively. The pharmacy encourages people to provide feedback about their experiences. It stores confidential information securely. And it mostly keeps the records required by law in good order. Pharmacy team members act with care to reduce risk following the mistakes they make during the dispensing process. And they review these actions regularly to ensure they remain effective. Pharmacy team members know how to recognise, and report concerns to help keep vulnerable people safe from harm. And they understand the importance of offering a safe space to people seeking support.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) to support its safe and effective running. The pharmacy manager regularly reviewed team member's training records to ensure they kept up to date with learning for the SOPs. And team members could take time at work to complete this learning. Pharmacy team members demonstrated how they followed SOPs with care. They followed the company's 'model day' task tracker to support them in completing their daily tasks. Information recorded on the trackers included the time team members had completed specific tasks. The pharmacy manager kept completed task trackers and reviewed these regularly. They explained how information such as times helped them to identify pressure points and risk and supported the team in identifying any areas for improvement. As well as the task trackers the pharmacy recorded key tasks such as monitoring emails. And the manager conducted a series of regular assurance checks for areas such as record keeping, storage of medicines and health and safety.

Pharmacy team members engaged in regular learning to help maintain patient safety. This learning included reading newsletters associated with providing services safely and exploring case studies about adverse events. They corrected and recorded the mistakes they made and identified during the dispensing process, known as near misses. A trainee pharmacy technician led a monthly patient safety review. All team members engaged in structured discussions and shared learning as part of these reviews. And the team recorded the details of these discussions and the actions it took to reduce risk. For example, team members checked pack sizes during the dispensing process to help reduce the risk of them dispensing the wrong quantity. The team regularly reviewed the actions to ensure they remained effective. The responsible pharmacist (RP) described how they would report and manage a mistake identified following the supply of a medicine to a person, known as a dispensing incident. This included speaking to the person affected, apologising, correcting the mistake, and reporting the incident. Dispensing incident records identified contributory factors and investigation notes to find the root cause of the mistake. They clearly identified learning points and actions taken to reduce the risk of a similar mistake occurring.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. A sample of pharmacy records examined mostly complied with legal requirements. The address of the wholesaler was not always recorded in the controlled drug (CD) register when a pharmacist entered the receipt of a CD. The pharmacy maintained running balances in the CD register

and completed full balance checks of physical stock against the register weekly. Physical balance checks of CDs conducted during the inspection complied with the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

The pharmacy advertised how people could provide feedback, this included promoting to people how they could feedback about their experience through a survey accessed by scanning quick response (QR) codes at the prescription reception counter. Pharmacy team members knew how to manage feedback and how to escalate a concern when required. The pharmacy held all confidential information in the staff-only area of the pharmacy. It segregated its confidential waste, and it securely disposed of this waste. All team members engaged in mandatory learning about data protection and confidentiality. The pharmacy advertised its consultation room as a safe space. Its team members knew what to do if a person requested access to a safe space or used code words promoted by national domestic violence safety initiatives. All team members engaged in safeguarding learning to help protect vulnerable people. And they had valuable information available to them to support them in recognising and raising safeguarding concerns, including GPhC guidance on Female Genital Mutilation (FGM) and contact information for safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people with the appropriate knowledge and skills to safely deliver its services. The pharmacy supports its team members through structured reviews, and it aligns training to the interests of its team members. It uses the feedback provided by team members to inform the safe delivery of its services. Pharmacy team members enthusiastically engage in continuous learning to support them in their roles. And they clearly show how they use the knowledge they gain from this learning when providing pharmacy services. Pharmacy team members engage in meaningful reviews about risk and patient safety. And they are empowered to provide feedback at work.

Inspector's evidence

The RP was an relief pharmacist, who worked at the pharmacy regularly. They were was supported by a self-employed locum pharmacist, who was familiar with the processes in the pharmacy. The pharmacy was operating with reduced staffing levels due to leave within the team. The pharmacy manager was a qualified dispenser. They were working alongside two other qualified dispensers. Workflow in the dispensary was efficient and the working atmosphere was calm despite staffing levels being lower than normal. Team members worked effectively together to complete key tasks in a timely manner. For example, unpacking the medicine order. The pharmacy employed two other qualified dispensers and a trainee pharmacy technician had a split role working between the pharmacy and another within the town. Two pharmacists generally worked two days a week and a vacancy for an accuracy checking pharmacy technician had recently been filled. The manager felt able to request support from the area relief team if required. Pharmacists felt able to apply their professional judgement when providing the pharmacy's services.

Pharmacy team members engaged in continual training to support them in their roles. This learning ranged from reading newsletters to completing e-learning and enrolment on structured learning programmes. For example, the pharmacy manager was enrolled on a leadership pathway programme. And recent learning for the programme had included the importance of applying the duty of candour when managing adverse events. The trainee pharmacy technician felt confident in asking for support with their learning. They had recently requested team members bring information about a range of topics to their attention to help them identify case studies relevant to their current learning. All team members had engaged in recent learning ahead of the rollout of the NHS Pharmacy First service. Team members demonstrated how they used the learning in practice. For example, by using the knowledge they had developed through completing antimicrobial stewardship learning when having conversations with people about treatments available through the service. Pharmacy team members engaged in regular conversations with their manager, including structured reviews to support their learning and development.

Pharmacy team members recorded the outcome of their patient safety reviews each month and team members were aware of current actions from these reviews. The pharmacy had a whistle blowing policy and its team members understood how they could raise and escalate a concern at work. The pharmacy promoted the availability of the company's confidential employee-assistance programme to its team members to support their health and wellbeing. Pharmacy team members felt confident to raise concerns and share ideas at work. And they provided examples of feedback they had raised when

identifying risk. For example, the pharmacy was due to join the company's hub and spoke dispensing service to support it in managing its workload. The go-live date for this was directly before a busy bank holiday weekend. The manager had escalated their concerns about this proposed date and the impact it could have on the ability of the team to manage all of the pharmacy's services safely and efficiently. As a result the roll-out date had been postponed to a more suitable date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They offer a professional environment for delivering healthcare services. People using the pharmacy can speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and well maintained. Team members knew how to report maintenance concerns. There was one outstanding maintenance issue waiting to be fixed. The issue did not affect the safe and effective running of the pharmacy. The pharmacy was subject to periodic health and safety checks and fire safety checks. Lighting was bright and air conditioning helped to provide an ambient temperature throughout the year. Team members had access to sinks equipped with antibacterial hand wash and paper towels.

The public area was fitted with wide-spaced aisles. The pharmacy's consultation room was an adequate size, and it was professional in appearance. The dispensary was a sufficient size for the level of activity taking place. The team managed workflow well. For example, it stored tubs of medicines with prescriptions waiting to be checked on designated shelves. This practice promoted a safe working environment as work benches remained free of clutter. A door to the side of the dispensary led to staff facilities and a small store area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has good risk management strategies to support it in safely delivering its services. It works well with other healthcare professionals. And it clearly demonstrates how people receive valuable care and support to effectively manage their health. The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy through a door from the onsite carpark or from an open-plan entrance leading from the medical centre. The pharmacy advertised its opening times and information about the services it provided. It also advertised how its team members were trained to recognise and support the individual needs of people, such as people with hidden disabilities who wore the sunflower lanyard. Pharmacy team members knew how to signpost people to other pharmacies or healthcare services when the pharmacy was unable to provide a service or supply a medicine.

The pharmacy team enjoyed a positive working relationship with the local GP surgeries. And it regularly shared information with GP surgery colleagues to support effective care. For example, the manager had attended local surgeries to provide information about the new NHS Pharmacy First Service.
They provided written information about the service to surgery teams. This included a laminated guide to the inclusion criteria for each of the seven conditions the pharmacy could treat through the service. Pharmacy team members checked for referrals regularly. The team acted quickly and with care when an unsuitable referral was received. They contacted people to explain why a referral was not appropriate for the pharmacy to treat, and to explore their symptoms further. They then worked together with GP surgeries to support people in accessing the care they required. All pharmacy team members had access to information to support their role within the Pharmacy First Service. Pharmacists providing the service had signed the patient group directions (PGDs). The pharmacy had shared its approach to setting up the service with other local pharmacies owned by the company.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were observed following procedures when responding to requests for P medicines. They recognised the importance of identifying repeat requests for medicines liable to abuse. A team member described the conversation they had with people purchasing codeine-containing medicines, and the importance of explaining to them the potential side effects and risk of driving when taking these medicines. Pharmacy team members handed out codeine care cards to support people in taking these medicines safely. And the manager discussed an option to support people with referrals to their GP if they had concerns about their use of these medicines. The pharmacy team used bright cards to identify higher-risk medicines during the dispensing process. The cards prompted extra checks during the dispensing process and contained key counselling points to discuss with people when handing out these medicines. A pharmacist discussed their approach to counselling people when handing out valproate. They were knowledgeable about the requirements of the valproate pregnancy prevention programme. And the team kept records of the checks it made when dispensing valproate to people. Pharmacy team members routinely recorded 'clinical effectiveness interventions' on people's medication records. This supported them in providing continual care to people and clearly showed how they had considered and

managed risk when supplying medicines.

Pharmacy team members signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to form a dispensing audit trail. They followed an effective system for managing medicines owed to people. They provided people with a copy of an owing slip detailing the medicine that was owed to them. And made regular checks of the medicines owed to people. They reserved the remaining quantity of an antibiotic solution when it wasn’t appropriate to provide the full quantity of the medicine at the start of a course. This was due to the shortened shelf life of these products once prepared by the pharmacy. They informed people and prescribers of medicine supply issues to help ensure people did not run out of their essential medicines. The pharmacy monitored the services it provided with care. Pharmacy team members engaged in learning ahead of clinical audits to ensure they understood the aims of the audits and in order to support them in collecting information accurately. Following audits, they engaged in feedback sessions to discuss the results and to share any learning points. For example, the team had implemented an action plan following a review of the palliative care service.

The pharmacy obtained its medicines from licensed wholesalers and a licensed specials manufacturer. It stored them neatly and mostly within their original packaging. A box of medicine containing four tablets was found to have a different batch number and expiry date to the blister strip of the four tablets inside the box. This was identified during a random balance check of CDs. The team acted appropriately to separate and label the box ready for destruction as the medicine’s expiry date was approaching. The manager planned to share this finding with team members during the next patient safety review. The team kept records of the checks it made on the expiry date of medicines, including maintaining a list of those with short expiry dates. And it highlighted short-dated medicines with stickers. A random check of stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates. This prompted additional checks during the dispensing process to ensure they were safe to supply to people. The pharmacy kept CDs in an orderly manner within secure cabinets. It stored medicines inside its fridges neatly. And it kept fridge temperature records showing fridges were operating within the required range of two and eight degrees Celsius. The pharmacy had appropriate medicine waste bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy team received medicine alerts by email. It kept a robust audit trail of the action it took in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment in needs to provide its services. It maintains its equipment appropriately. And its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy stored bags of assembled medicines safely in a retrieval area within the dispensary. It suitably protected information on its computer monitors from unauthorised view. Pharmacy team members had access to a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone. And they used NHS smartcards and passwords when accessing people's medication records. Pharmacy team members had access to a wide range of reference resources. They accessed the internet to support them in obtaining information and could telephone a dedicated support service provided by the pharmacy's head office team.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicines and clean counting equipment for counting tablets and capsules. The pharmacy stored the equipment to support the pharmacy's consultation services was safely within the pharmacy's consultation room. The equipment was from recognised manufacturers. And team members regularly cleaned the equipment and checked it before use. The pharmacy's electrical equipment was subject to periodic safety checks.

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.