General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 6, Guiseley Retail Park, Park Road Guiseley, LEEDS, West Yorkshire, LS20 8QH

Pharmacy reference: 1107591

Type of pharmacy: Community

Date of inspection: 25/07/2019

Pharmacy context

The pharmacy is in a retail park in the centre of Guiseley. The pharmacy dispenses NHS and private prescriptions. And it provides medication in multi-compartmental compliance packs to help people take their medicines. The pharmacy offers a private chickenpox vaccination service. And it provides flu vaccinations.

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	2.2	Good practice	The pharmacy provides training to team members tailored to the services they provide. And it offers all team members opportunities to complete more training. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career.
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. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. The pharmacy has appropriate arrangements to protect people's private information. The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

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 pharmacy had a new set of SOPs to cover the changes to some processes following a recent computer upgrade. The team had read the SOPs and signed the signature sheets to show they understood and would follow the SOPs. 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 errors. And each team member completed their own record. A sample of the error records looked at found the team captured details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The pharmacy attached labels to shelves holding items that looked and sounded alike (LASA). This included medication such as atenolol and allopurinol. The labels prompted the team to check the medicine selected. The team also attached to each computer terminal a list of common LASA medication identified across the company. Following a dispensing incident involving pregabalin and gabapentin the team members had added these two medicines to the LASA list.

The pharmacy undertook a monthly patient safety review. One of the dispensers led on this and shared the results with the team members. A recent review reminded the team to ensure the error logs were fully completed to help with the analysis of mistakes. This review asked the team to take care when checking more than one prescription for the same person. So, medicines were not missed. The report commented that dealing with missing items added to the team's workload. The pharmacy also completed an annual patient safety review. The latest report highlighted a change to process the team had introduced to reduce errors with walk-in prescriptions. Previously the team dispensed and checked all walk-in prescriptions at the front section of the dispensary where people waited for their prescriptions. This meant people waiting for their prescriptions may distract the team. Now the team dispense and check walk-in prescriptions with more than three items in the rear dispensary, away from any distractions. 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.

A sample of controlled drugs (CD) registers looked at found 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 private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding policy and team members had access to contact numbers for local safeguarding teams. The pharmacists and pharmacy technician had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) in 2017 on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017 and 2018. The team had not had the occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And the team members support each other in their day-to-day work. The pharmacy provides training to team members tailored to the services they provide. And it offers all team members opportunities to complete more training. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. The team members discuss how they can make improvements. And they agree new processes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

Three regular pharmacists covered the pharmacy opening hours. Boots relief pharmacists provided support when required. Two pharmacists usually overlapped on a Thursday. This supported the pharmacists with delivering services such as the chickenpox vaccination service. And gave the pharmacist time to spend with the person receiving the vaccination. The pharmacy team consisted of pharmacy pre-registration student, an accuracy checking pharmacy technician (ACT), seven qualified dispensers and a trainee healthcare assistant. One of the qualified dispensers was the pharmacy manager. The team shared key tasks such as managing the service providing the multi-compartmental compliance packs. This ensured team members had a range of skills and could support the service in times of absence.

One of the regular pharmacists was the tutor for the pre-registration student. The two had discussed the year ahead based on the structured programme and personal objectives of the student. This included experience at a Boots pharmacy that supplied medicines to care homes. The team often referred queries from people to the student as part of their learning and development.

The pharmacists providing the chickenpox vaccination service had completed specific training. The training included how to manage children's anxieties or behaviours linked to the administration of the vaccine. The pharmacy provided the team with extra training on a range of subjects through e-learning modules. And it undertook performance reviews with the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had relocated to the pharmacy and enrolled on to a manager training course.

The pharmacy held weekly team meetings to discuss errors and incidents along with new company initiatives. Team members could suggest changes to processes or new ideas of working. The team members had discussed and implemented a three-way check of the quantity of medicines dispensed. To reduce the number of errors involving incorrect quantities. This included a mark on the internal part of the packaging to show that the team member had counted the contents. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And the pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

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 and it had alcohol gel for hand cleansing. The team members used disposable gloves when dispensing medicines in to the multi-compartmental compliance packs. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The room was a little distance from the pharmacy counter. The pharmacy didn’t have a notice or other information source to inform people of the availability of the room. The pharmacy provided a screened area for people to take their methadone doses in private. The premises were secure. And the pharmacy had restricted access to the dispensary during the opening hours. 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 provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a step free entrance through an automatic door. Or using a drive-through facility. The drive-through section of the pharmacy had two windows. One for the person to hand in their prescription, And a second for the supply of their medicines. The drive-through was popular with parents with young children and people with a physical disability. The team promoted the drive-through facility during conversations with people about how they could access the pharmacy. The window displays detailed the opening times and the services offered. And an information leaflet provided people with 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 health information leaflets for people to read or take away. And the team wore name badges detailing their role.

Two of the regular pharmacists were authorised to administer the chickenpox vaccine from an up-to-date patient group direction (PGD). The team offered the service when the pharmacy had more than one pharmacist on duty. So, the pharmacist could spend time with the person before and after the administration of the vaccine. The pharmacy had in date adrenaline injections in case anyone had an anaphylactic reaction to the vaccines.

The pharmacy provided multi-compartmental compliance packs to help around 90 people take their medicines. The pharmacy was at capacity for this service. So, the team directed people requiring the packs to another Boots pharmacy that could support this service. The team members had recently completed a training course to help them identify people who were suitable for this service. And to offer people who were not suitable alternate support. Such as a chart to remind the person when to take their medicines. And to record when they had taken their medication. People received monthly or weekly supplies depending on their needs. Or, if their medicines regularly changed. Four of the dispensers managed the service between them. And they divided the preparation of the packs across the month. Each week was colour coded. This helped to manage the workload and for the team to track the completion of the different stages. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Despite ordering the prescriptions early a few GP teams sent the prescription on the day of supply. The team members knew which person the late prescriptions were for. So, planned their workload to enable them to dispense and check the pack as soon as the prescription arrived. The pharmacy team had spoken to the GP teams about this. But the process had not changed. Each person had a record listing their current medication, dosage and dose times. The team members checked received prescriptions against the list. And they queried any changes with the GP team. The team members marked the list to show they had completed the checks.

After checking the prescriptions, the team generated the dispensing labels and ordered the medicines. By ordering the medicine at the point of labelling the stock arrived separately making it easier to locate.

The team members scanned the medicine packaging before removing the items to ensure they had selected the correct medication. Before dispensing the team members placed the stock picked, the prescription and the medication list in a box file labelled with the person's name and address. So, everything was ready when the time came to dispense. The team members used a section at the back of the main dispensary or a room separate to the dispensary and retail areas to dispense the medication in to the packs. This meant they were less likely to be disturbed when dispensing. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The team stored completed packs in the box files labelled with the person's name and address. The team separated packs for people who were in hospital. And sometimes the pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And shared this with the GP team. The pharmacy team had asked the GP teams to inform the pharmacy of medicine changes as soon as possible. And to use a specific form to detail the changes. But the GP teams had yet to put this in place. The pharmacy team kept a communications record for each person. This detailed any information received about the person and the actions taken by the team in response. The team kept the communication sheet with the medication list to refer to if queries arose.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And separated people's doses to reduce the risk of selecting the wrong one. The team members provided a repeat prescription ordering service. They used an electronic system to remind them when they had to request the prescription. And they used this as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used tubs 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. This helped to ensure they picked the correct item. The pharmacy team members used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person that they had obtained from the electronic medication record (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. 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 team members used this as a prompt to check what they had picked. The pharmacy team had completed checks to identify people who met the criteria of the valproate Pregnancy Prevention Programme (PPP). And to ensure anyone who met the criteria received appropriate advice. The pharmacy had the PPP pack to provide information to people when required.

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 stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The team used the PIF to highlight the prescription had a CD. And it also marked the CD on the prescription when there was more than one medicine listed. This alerted the team to the CD amongst the other items on the prescription. 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 pharmacy computer system monitored medicines often owed to people. And the team increased the stock levels if needed. This helped to reduce the number of owings the team made to people. 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. And the pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And it kept a record of this. The last date check was on 14 July 2019. The team used a 'caution short dated stock' sticker 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 oxybutynin oral solution with 30 days use once opened had a date of opening of 05 July 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. Following a dispensing error with a fridge medicine the team changed the checking process for fridge medicines from checking all fridge lines together. The team now checked one prescription at a time with all the other medicines on the prescription for the person. The team used laminate cards to alert the team member checking the prescription that fridges lines were included. 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 no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). 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 two fridges to store medicines kept at these temperatures. The team used one for storing stock and the other for completed prescriptions awaiting supply. 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.