General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Pocklington Medical Centre, 1 Amos Drive, Pocklington, York, East Riding of Yorkshire, YO42 2BS

Pharmacy reference: 9010075

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

This community pharmacy is in a medical centre in the large market town of Pocklington. The pharmacy dispenses NHS and private prescriptions. The pharmacy provides medication in multi-compartmental compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy offers a seasonal flu vaccination service. And a substance misuse 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	2.5	Good practice	The pharmacy team members look for ways to improve. And they change how they work to help provide safer and more effective services.
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 mostly keeps the records it needs to by law. The pharmacy has up-to-date written procedures that the team follows. And it has appropriate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team members have training, guidance and experience to respond well to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond well when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team does not have all the information it could to help identify patterns and reduce mistakes.

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 SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs included signature sheets for the team members to complete to show they had read the SOPs. And to show that they understood and would follow the SOPs. The team was reading through the updated SOPs. And signing the signature sheets as they completed each SOP. The team had signed the previous versions of 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 near miss errors. The pharmacist completed the records after discussing the mistake with the team member involved. Each team member had their own error record. A sample of the near miss error records looked at found that the team recorded 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 completed an electronic report of dispensing incidents. And sent it to Boots head office. The pharmacy had trained all the team to complete the report to ensure it was done in a timely manner. The team members discussed each dispensing incident and the impact the error had on the person who received the wrong medicine. The team also discussed how to prevent the error from happening again.

The pharmacy undertook a monthly patient safety review. The trainee accuracy checking technician and one of the regular pharmacists led on this and shared the results with the team members. The pharmacy displayed the outcome from the latest review in the dispensary for the team to refer to. A recent review reminded the team of the importance of clearly marking split boxes. And reminded the team to be extra careful as the updated computer system did not flag up differences with packs sizes for the same medicine. The team members attached warning labels to the shelves holding medicines that came in different packs sizes. To alert them to the fact there was more than one pack size. The pharmacy had labels that asked the team to select and speak the product selected. The team attached these labels to shelves holding items that looked and sounded alike (LASA). The pharmacy displayed laminate cards next to the computer terminals listing the LASA medicines for the team to refer to.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. There was no leaflet or other information source to provide 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 that 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. The Responsible Pharmacist notice was on a wall behind the pharmacy counter. But it was some distance from the pharmacy counter, so it was not obvious to most people at the counter. Records of private prescription supplies, and emergency supply requests met legal requirements. Most of the records kept by the pharmacy for the receipt and supply of unlicensed products 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 had a leaflet informing people about the confidential data it kept. And it displayed a notice about the fair processing of data. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And it provides all team members with 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 pharmacy supports an open and honest culture with the team. The team members are good at supporting each other in their day-to-day work. And they openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacy team members look for ways to improve. And they change how they work to help provide safer and more effective services.

Inspector's evidence

One full-time branch pharmacist and one part-time branch pharmacist covered most of the opening hours. Branch pharmacists from the other Boots in Pocklington and Boots relief pharmacists provided support when required. On several occasions over the week two pharmacists worked together. The pharmacists used this time to catch up with checking prescriptions. And to provide services such as the flu vaccinations. The pharmacy team consisted of one full-time registered pharmacy technician who was training to be an accuracy checking technician (ACT), three full-time dispensers, one who was the pharmacy manager, three part-time dispensers and a part-time trainee dispenser. During the inspection three pharmacists, the trainee ACT, the pharmacy manager, two dispensers and the trainee dispenser were on duty.

The pharmacy manager often liaised with the team at the other Boots in Pocklington to arrange cover to help manage the team's workload. The pharmacy trained the team on key tasks. This ensured the team members had a range of skills, so they could support the pharmacy services in times of absence.

The pharmacy provided extra training through e-learning modules. The team members had protected time to complete the training. Recent training included the reporting of dispensing incidents and the impact of dispensing errors on people. The pharmacy held weekly team meetings. And the team had a morning huddle to plan the day ahead. One of the regular pharmacists was arranging weekly meetings with the team to discuss patterns in near miss errors identified by the pharmacists.

The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had taken the opportunity to ask about training to be a pharmacy technician. Team members could suggest changes to processes or new ideas of working. Two of the team had re-arranged the storage of medicines to create more space. This helped the team to locate medicines as the stock was easier to see. And the new arrangements had provided a section for the team to place dispensed prescriptions awaiting a check by the trainee ACT. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was some pressure to achieve them. But the pharmacist offered the services when they would benefit people. The pharmacy team supported the pharmacists in delivering the flu vaccination service. The team advised people presenting with prescriptions the waiting time whilst the pharmacist was busy with the flu vaccination service. So, the person could wait or call back.

Principle 3 - Premises ✔ Standards met

Summary findings

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

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 alcohol gel for hand cleansing. 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 premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. 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 obtains is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door. The team had access to the internet to direct people to other healthcare services. The pharmacy had recently changed its opening hours. So, on a Tuesday it stayed open until 8pm. This reflected the change in hours at the medical centre. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). These gave the pharmacists the legal authority to administer the flu vaccines. The pharmacy had in-date adrenaline injections available in case the person receiving the flu vaccine had an anaphylactic reaction. The flu vaccination service was popular. People commented on the convenience of the service. And the gentle technique employed by the pharmacists when administering the vaccination. The team invited people to attend a walk-in service. Or gave the person an appointment when there were two pharmacists on duty together.

The pharmacy provided multi-compartmental compliance packs to help six people take their medicines. The pharmacy had provided the service to more people. But as the pharmacy workload increased the team moved most people's prescriptions to the other Boots pharmacy in Pocklington. As the team at the other Boots had the capacity to provide the service. The pharmacy team had obtained consent from people for this move. People received monthly or weekly supplies depending on their needs. 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. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The team also provided administration charts for people to help them remember to take their medicines. And to record when they had taken their medicine.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance 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 in separate plastic tubs with the prescription. So, this reduced the risk of the team selecting the wrong one. The team members provided a repeat prescription ordering service for people who met certain criteria set by the GP team. The team worked with the pharmacist based at the medical centre when the GP team stopped accepting repeat prescription requests from the pharmacy team. So, they could identify people who would struggle to order their prescriptions without the help of the pharmacy team. The GP team agreed that the people identified by the pharmacy could continue to use the pharmacy repeat prescription ordering service. The team members filed the repeat prescription slips in date order when the request was due. And they had an audit trail to track the requests. So, they could identify missing

prescriptions and chase them up with the GP teams. 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 pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets 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. So, they had a prompt to check what they had picked. The pharmacy team used a pharmacist information form (PIF) to alert the pharmacist to information about the prescription or person obtained from the electronic medication record (PMR) during labelling. These forms included dose changes or new medication. 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. And the team used the PIF to highlight prescriptions handed in by one person but for two different people such as a husband and wife. In such circumstances the PIF had 'Mr' and 'Mrs' written on. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The team 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 received on to the electronic record (PMR).

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 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. The pharmacy obtained separate signatures for CD deliveries. The team could access the delivery system to track the deliveries and see the signatures when queries arose.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 01 October 2019. The team had got slightly behind with this. And recent safety reports had highlighted the risk of supplying out of date medicines. So, the team had focused on completing this task. 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 Oramorph oral solution with three months use once opened had a date of opening of 01 October 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. 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 equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team members had received FMD training. And they were scanning FMD compliant packs. The pharmacy team found the number of picking errors had reduced since starting to use the FMD scanners. 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 internal notifications. 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 it mostly uses it to 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 it used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. The pharmacy used one fridge for stock. And it used the other fridge for completed prescriptions awaiting supply to the person. 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. And it kept the computer in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. However, some completed consent forms containing people's private information were stored in an unlocked filing cabinet in the consultation room. The pharmacy manager locked the filing cabinet after this was highlighted. The consultation room was locked when not in use. 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.