General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 3, The Springs, Thorpe Park Approach, Leeds, LS15 8GG

Pharmacy reference: 9011013

Type of pharmacy: Community

Date of inspection: 04/07/2022

Pharmacy context

This community pharmacy is in a large retail park on the outskirts of Leeds. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. And it supplies some medicines in multi-compartment compliance packs to help people take their medication. The pharmacy provides a private travel clinic.

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 appropriately identifies and manages the risks associated with its services. It has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. The pharmacy team members respond well when errors occur. They openly discuss what happened and they take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. The SOPs provided the team with information to perform tasks supporting the delivery of services. The team members accessed the SOPs and answered a few questions to confirm they had read and understood them. The team received alerts about new SOPs or changes to existing SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. They referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. The pharmacy kept records of these errors known as near misses. The team members recorded details of the error such as wrong quantities dispensed but they didn't always capture what had contributed to it. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing an electronic dispensing incident report to send to head office. The pharmacy undertook monthly reviews of the near miss errors and dispensing incidents. The outcome from the review was shared with team members who discussed the changes they could make to prevent future errors. The team recently discussed how to reduce near miss errors caused by workplace pressures. And agreed to provide people with accurate waiting times for prescriptions to be dispensed, so people could choose to wait or call back. A summary of the recent review was displayed in the dispensary for the team to refer to. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A leaflet provided people with information on how to raise a concern with the pharmacy team.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The balance of CDs was regularly checked to spot errors such as missed entries. A random check of the balance of a CD register found it was correct. The team recorded CDs returned by people for destruction. A sample of records for the receipt and supply of unlicensed products found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). 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 members completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the qualifications and skills to support its services. Team members work well together and support each other in their day-to-day work and when training. They openly discuss errors so everyone can learn from them and improve their skills. The team members regularly meet and discuss what they can improve on. And they agree new processes to help them efficiently deliver the pharmacy's services.

Inspector's evidence

A full-time pharmacist and a part-time pharmacist covered most of the opening hours. Locum pharmacists provided additional support when required. The pharmacy team consisted of a full-time qualified dispenser who had recently enrolled onto a pharmacy technician course, a full-time trainee dispenser and a full-time pharmacy student. At the time of the inspection the full-time pharmacist, the trainee dispenser and the pharmacy student were on duty. The team worked well together especially at busy times.

The team members used company online training modules to keep their knowledge up to date. The team members had some protected time at work to complete the training but this depended on how many team members were on duty. The pharmacy provided team members with informal and formal feedback on their performance reviews. This gave them a chance to receive individual feedback and discuss their development needs. The trainee dispenser was due to finish their course in a few weeks and had received support from the other team members throughout their training.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the dispensers had suggested setting-up a rota between them to work Monday evening between 8pm and 11pm to focus on processing the compliance packs. This had been implemented and the team reported it had helped them manage their workload. The pharmacy used a popular communication platform to ensure all team members had up-to-date information such as new services or training modules.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were hygienic and tidy. The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock, assembled medicines and medical devices and the team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy was secure and it 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. The pharmacy had a large, soundproof consultation room which the team used for private conversations with people. The room was well equipped to support the range of services provided. And it contained a sink and hand sanitiser. The pharmacy had a separate area to enable people collecting their supervised doses of medication to do so in private.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which support people's health needs and it manages these services well. The pharmacy gets its medicines from reputable sources and it stores and manages them correctly. The team members generally carry out appropriate checks to make sure medicines are in good condition and suitable to supply. Team members clearly highlight prescriptions for high-risk medicines to make sure people receive appropriate advice and information to take their medicines safely.

Inspector's evidence

People accessed the pharmacy via the main store entrance through an automatic door. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. 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 so people using the pharmacy knew who they were speaking to. Team members asked appropriate questions when selling over-the-counter products and they provided people with clear advice on how to use their medicines. The dispensers used laminated alert cards to prompt the pharmacist to ask for information from people prescribed high-risk medicines such as warfarin. The pharmacist typically captured key points from the conversation with the person on to the electronic patient record (PMR). The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had alerted each other to changes with the manufacturer’s packaging that enabled the dispensing label to be attached to the box without interfering with the PPP card embedded in the packaging.

The pharmacy provided a private travel vaccination and advice service. The person used an online booking system to make an appointment which usually lasted 45 minutes. The person had a remote consultation with a prescriber who advised the person of the vaccines required for the areas they were travelling to along with any malaria prevention medicine. The decision to have the vaccine and malaria prevention medicine lay with the person. Once the person decided to receive the vaccine the prescriber generated a prescription for the appropriate vaccine and malaria prevention medicines. The prescription gave the pharmacist the legal authority to administer the vaccine. The pharmacist also provided general travel health advice to the person. The pharmacist had access to adrenaline injections to administer when a person experienced an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 21 people take their medicines. To manage the workload the team divided the preparation of the packs across the month and mostly prepared them of an evening when the pharmacy was less busy. The team generally ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items and the dispensing of the medication into the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team usually recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries which the team checked for changes or new items. The pharmacy supplied medicines to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacist

stored the prepared doses in the controlled drugs cabinet in separate sections labelled with the person's name.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Tubs were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. 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 found that the team completed the boxes. The pharmacy team added information from the PMR to a label attached to the prescription. This alerted the pharmacist to information about the prescription or person obtained from PMR during labelling, such as dose changes. 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 fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. And they kept a list of medicines due to expire each month. No out-of-date stock was found. The team members usually recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. However, an opened bottle of Cetirizine oral solution with six months use once opened didn't have a date of opening recorded. The team checked and recorded fridge temperatures on most days. A sample of fridge temperature records found a few gaps for the recently installed fridge. The records that were captured for all fridges showed the temperatures 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 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 received alerts about medicines and medical devices from the MHRA via email. The team usually 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 to appropriately protect people's confidential 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 had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy completed safety checks on its electrical equipment. The pharmacy 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 confidential information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.