General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 36 High Street, Alfreton, DERBY, Derbyshire, DE55 7BL

Pharmacy reference: 1030360

Type of pharmacy: Community

Date of inspection: 30/09/2024

Pharmacy context

This community pharmacy is located in the town centre. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. And it provides a seasonal flu vaccination service and some other NHS funded services including the Pharmacy First Service. It supplies medicines to people living in care homes.

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	The pharmacy team records and analyses adverse dispensing incidents. It identifies learning points and shares them within the team, and with other pharmacies to help manage future risks.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their roles. And the pharmacy supports their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team works well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
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 effectively manages risks to make sure its services are safe, and it acts to improve patient safety. Pharmacy team members accurately complete all the records that they need to by law. They record their mistakes so that they can learn from them, and they act to help stop the same sort of mistakes from happening again. Pharmacy team members work to professional standards, and they are clear about their roles and responsibilities. The team members keep people's private information safe, and they understand how they can help to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided which were available in electronic format. Members of the pharmacy team confirmed via an e-Learning system that they had read and accepted the SOPs. And they completed a quiz to test their understanding of each SOP. The team were sent updates when a new SOP was available, or when one had been reviewed. These had to be read within a set timeframe. The pharmacy's managers and the pharmacist superintendent's (SI) office could monitor which team members had outstanding SOPs to read, so these could be followed up. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. They were wearing uniforms and badges which identified their roles. The incorrect responsible pharmacist (RP) notice was on display at the start of the inspection, but this was promptly changed when it was pointed out.

The pharmacy team reported near misses and dispensing incidents on the Boots electronic reporting system which could be viewed by the SI office. The pharmacy's patient safety champion reviewed these on a regular basis as part of the monthly patient safety review and discussed them with the team. Learning points were identified and the team were usually set three areas to focus on for the following month. These were displayed on notice boards in the dispensary and in the care home room. A dispenser said she felt comfortable reporting errors and felt that learning from mistakes was encouraged. Current areas that the team were working on was to ensure the dispensary was kept clean and tidy and stock was always in the correct places to minimise errors. Lists of the most common look-alike and sound-alike drugs 'LASAs' were on display. The pharmacy's Patient Medication Record (PMR) system had an added patient safety feature using bar code technology which checked that the medicine selected was the one that was prescribed. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. A 'Professional Standards Bulletin' was received from head office each month which team members read and signed. It included case studies on incidents that had happened in other pharmacies with points for reflection. A recent bulletin had an article to help team members respond to over- the- counter requests for cyclizine, and there was a link to a patient safety spotlight on cyclizine in the GPhC's online magazine 'Regulate.' The bulletin also included a patient safety letter, encouraging teams to review their accuracy checking process and workflow. A pharmacist's log was completed daily and weekly. The fridge temperature, RP notice, controlled drug (CD) key security and CD records were checked as part of this.

New Services were assessed before the pharmacy started offering them. For example, the pharmacy completed checks before it provided its seasonal flu vaccination service. There were notices displayed in the consultation room explaining the symptoms and treatment of fainting, seizures and anaphylaxis,

and the process to follow if there was a needle-stick injury or accidental exposure to blood. This helped the team to manage the risks associated with the flu vaccination service.

There was an SOP for dealing with complaints. 'About this pharmacy' leaflets were on display which gave details of the complaints procedure and encouraged people to give suggestions or feedback on the pharmacy services. Pharmacy customer satisfaction cards were available at the pharmacy reception and at the medicine counter to encourage people to give feedback on their experience. The assistant manager explained that feedback was generally very positive about the pharmacy team. For example, several people had reported good experiences during Pharmacy First consultations with the regular pharmacist, whom they found particularly knowledgeable and helpful.

Professional indemnity insurance arrangements were in place. Private prescription records, the RP record and the CD registers were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

Members of the pharmacy team had annual training on information governance (IG) and confidentiality. Confidential waste was placed in designated bags which were collected and taken for safe disposal. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions and paperwork containing patient confidential information were stored appropriately so that people's details could not be seen by members of the public. An explanation about information sharing and the NHS Code of Confidentiality was given in 'About this pharmacy' leaflets. The pharmacy's fair data processing notice was on display. Some small 'waiting' prescriptions were dispensed on the bench at the pharmacy's reception. The RP explained that if somebody was standing at the desk, then she would ensure that the prescriptions were hidden behind notices on the reception desk to avoid breaching people's confidentiality.

The RP had completed level three training on safeguarding. Other staff had completed training at a level appropriate to their role. A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a safeguarding notice on display in the dispensary with the names of the safeguarding leads within the company, who could be contacted for advice. The pharmacy had a chaperone policy. This was highlighted on a notice displayed inside the consultation room, so might not be seen by everyone visiting the pharmacy. The pharmacy was registered as a 'Safe Space' for victims of domestic abuse. The notice highlighting this was also inside the consultation room, so it might not be easily seen by people who needed support. The assistant manager said she would move both notices to a more prominent place in the retail area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are well trained, and they work effectively together in a busy environment. The pharmacy encourages team members to keep their skills up to date and supports their development. Team members have opportunities to discuss issues together. They are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

The RP, the assistant manager, a trainee pharmacist, and two NVQ2 qualified dispensers (or equivalent) were on duty in the main pharmacy area on the ground floor at the time of the inspection. The assistant manager was a qualified dispenser. The store manager was also a qualified dispenser, but she was not present at the inspection. The staffing level was adequate for the volume of work during the inspection and the team members were observed working collaboratively with each other and people who visited the pharmacy. An accuracy checking technician (ACT) and four NVQ2 qualified dispensers (or equivalent) made up the care home team which was situated on the first floor. Absences were covered by re-arranging the staff hours or transferring staff from neighbouring branches. The pharmacy was one of 19 branches in the area. The area manager could be contacted to arrange staff transfers when necessary.

Members of the pharmacy team carrying out the services had completed appropriate training. They used the e-Learning system to ensure their training was up to date and had completed recent training on the NHS Pharmacy First service. Team members had allocated training time when required. The regular pharmacist was the trainee pharmacist's tutor and was supervising his foundation training. The trainee pharmacist was carrying out flu vaccinations. He had complete online and face-to-face training, and he had shadowed, and been observed by the regular pharmacist, before carrying out the vaccines on his own.

The pharmacy team were given formal appraisals where performance and development were discussed with their line manager. Daily team meetings were held where a variety of issues were discussed. All team members were in an electronic messenger group which was used to ensure that everyone was included. There was an area call every week which one of the pharmacy's managers attended and they cascaded the information to the rest of the team. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the regular pharmacist or one of the managers about any concerns she might have. She said team members could make suggestions or criticisms informally. There were wellbeing notices in the staff tearoom and a notice displaying the details of the company's compliance and ethics hotline.

The pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because they felt it was inappropriate. The RP said targets were set for certain services, but she felt they were manageable, and she didn't feel under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has a consultation room so people can receive services and have confidential conversations with members of the pharmacy team in private.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean and in a good state of repair. There was a regular cleaner provided by a third party, and a cleaning schedule was used. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue.

The pharmacy was in a large premises which had two floors. There was a care home room, stockroom, training room and staff facilities on the first floor. Staff facilities included a kitchen, a staff tearoom, and WCs with wash hand basins. There were dispensary sinks in the care home room as well as the main dispensary for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. The pharmacy was participating in 'Our future Health' research programme. A section of the pharmacy was screened off for the clinic. There were an additional three chairs in its waiting area.

The consultation room was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services such as flu vaccinations and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are well managed and easy for people to access. The pharmacy sources, stores, and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to everyone, including people with mobility difficulties and wheelchair users. A list of the services provided by the pharmacy was shown in the 'About this Pharmacy' leaflets, and some services were advertised in the pharmacy. There was a range of healthcare leaflets and support available to people. For example, Hearing Help UK and the NHS Pharmacy First service. There were posters advertising local support services. For example, Derbyshire victims of sexual assault. Boxes for recycling insulin pens were available, with relevant information for people wishing to use the recycling service.

There was a home delivery service with associated audit trail. Each delivery was recorded electronically, and a record of who had accepted the delivery was reported. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. A care services medicines delivery book was used to record deliveries made to care homes. This required a signature from an appropriate person at the care home, and they were given the top page. The carbon copy in the book was retained by the pharmacy for reference.

Space was quite limited in the main dispensary, but the workflow was organised into separate areas. The dispensary shelves were neat, and tidy. A new system called Advanced Due Date Dispensing (A-DDD) had been introduced where the required stock for each prescription was collected and sent from the hub. This increased efficiency and bar code technology ensured accuracy. A grid was completed on the prescription to show who had made the data entry, dispensed, clinically checked, and handed out the prescription. The RP completed an accuracy check of the data entry and of assembled prescriptions which had been assembled outside of the A-DDD process. Dispensed by and checked by boxes were initialled on the medication labels for these prescriptions. This provided an audit trail of the person who had accuracy checked the medicine and these details were also added to the grid on the prescription. Tubs were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up.

The PMR system generated prompts which came up when prescriptions were scanned at handout for high-risk medicines. For example, questions about Pregnancy Prevention Programme (PPP) and specialist reviews when handing out prescriptions for medicines containing valproate, and INR level checks for warfarin prescriptions. The pharmacist could add additional prompts manually if there was a particular counselling point they wanted to provide. The team member had to respond to the prompt before they could complete the handout, and this provided an audit trail. Electronic Pharmacist information (PIF) forms were automatically updated by the PMR system to alert the pharmacist to changes in dosage or formulation. Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed, and these details were also highlighted on prescriptions.

The pharmacy received some prescriptions from their online prescribing service, including prescriptions for weight loss medicines. The RP explained that she would contact the prescriber if she had any concerns about a person collecting a medicine for weight loss. For example, if they did not appear to be overweight. It wasn't a requirement for the person to collect the medicine themselves, and the pharmacy team members weren't required to verify people's weight.

The pharmacy supplied all the care homes with medicines in original packs. The care homes were split into four weeks to help manage the workload. Each month the care homes were sent a 'next cycle summary report' for them to check and follow up any missing prescriptions. A pharmacy communication form was used by the care homes to notify the pharmacy of any new residents, new medicines, or changes. Most care homes were provided with electronic medicine administration record sheets (eMAR). They were sent to the relevant care home when the medicines were ready for delivery. The RP clinically checked the prescriptions and an ACT carried out the accuracy checks for patients in the care homes. A small number of multi-compartment compliance aid packs were provided to people in the community. These were well managed with an audit trail for communications with GPs and changes to medication. Disposable equipment was used.

A dispenser explained what questions she asked when making a medicine sale and she knew when to refer the person to a pharmacist. The dispenser was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be misusing medicines, such as a codeine containing product.

People attending the 'Our future Health' clinic as volunteers provided blood samples and had some physical measurements taken, including blood pressure and cholesterol tests. There were two qualified phlebotomists who carried out the tests and they were employed by Boots. The programme was partnered with the NHS. The clinic generated a large amount of clinical waste. The pharmacy had arranged extra collections of this, and the sharps bins and other clinical waste were stored safely until collection.

CDs were stored in a CD cabinet which was securely fixed to the floor. The keys were under the control of the RP during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via electronic messages from head office. These were printed off and acted on by a member of the pharmacy team. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. The RP explained she usually accessed the electronic British National Formulary (BNF) and the Summary of Product Characteristics (SPC) on her mobile phone, but they were also available on the pharmacy's computers.

There were two clean medical fridges for storing medicines, one in the dispensary and one in the care home room. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. A sharps bin and other equipment required for the flu vaccination service was available in the consultation room.

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.