General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 214 Fulwood Road, Broomhill, SHEFFIELD, South Yorkshire, S10 3BB

Pharmacy reference: 1039297

Type of pharmacy: Community

Date of inspection: 09/07/2024

Pharmacy context

This is a community pharmacy in the main shopping area of Fulwood, in the city of Sheffield. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy offers other services such as the NHS blood pressure check service and the NHS Pharmacy First service. The pharmacy supplies some people with their medicines dispensed into multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers some medicines to people's homes.

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's team members have access to a comprehensive set of written procedures to help them manage the services provided to people. They have the appropriate training to help support the safeguarding of vulnerable adults and children. The pharmacy mostly keeps people's sensitive information secure. Team members recognise the importance of recording and reflecting on any mistakes made during the dispensing process. They look to identify trends or patterns in the records and implement changes to the way they work to manage risks.

Inspector's evidence

The pharmacy had a comprehensive set of digital and written standard operating procedures (SOPs) available for its team to use. The SOPs provided the team members with information to help them complete various tasks. For example, managing controlled drugs (CDs). The SOPs were updated every two years to ensure they accurately reflected the pharmacy's services. The written SOPs were stored in a folder. Within the folder there was information which indicated if a digital version of an SOP was available. Team members read the SOPs when they were introduced and updated. They signed a document to confirm they had read and understood each SOP that was relevant to their role. The pharmacy's manager had overall oversight of this process and was alerted by the pharmacy's senior management team if a team member was required to review an SOP. Team members completed a short assessment after they read an SOP to test their understanding and there was a record confirming which SOP each team member had completed.

The team used a digital system to record mistakes made during the dispensing process which were identified before a medicine was supplied to a person. These mistakes were known as near misses. Each team member understood how to use the system to record details of a near miss. Team members recorded the time and date a near miss happened, and a description of any contributing factors. The pharmacy had nominated a team member the role of 'Patient Safety Champion' (PSC). At the end of each month, the PSC analysed the near misses and discussed the findings with the team through a patient safety review meeting. Team members considered ways they could improve and implemented some action points for them to complete. These action points were documented and displayed on a wall in the dispensary. Team members were required to sign the document to confirm they had read and understood it. The most recent action points included the team discussing the importance of recording each near miss as some near misses had not been recorded due to workload pressures.

The team used the same system to report and record dispensing incidents that had reached people. The team followed a process to investigate the incident to help establish any contributing factors that may have caused the error and implement an action plan to reduce the risk of a similar mistake recurring. The pharmacy advertised its feedback and complaints procedure to people that used the pharmacy. Team members supplied people who used its services with cards which had details of the pharmacy's website for people to access. People were encouraged to access the website which led to an online feedback questionnaire. The questionnaire asked questions about people's experience of using the pharmacy's services. Team members wrote their first names on the cards to help people give specific feedback about the services they received.

The pharmacy had current professional indemnity insurance. It displayed a responsible pharmacist

(RP) notice which could be easily seen from the retail area. The notice displayed the correct details of the RP on duty. A sample of the RP record inspected was completed correctly. However, on the day of the inspection the RP had recorded the time their RP duties were due to end. The importance of ensuring this time was only recorded when the RP had completed their RP duties was discussed. The pharmacy kept complete records of supplies against private prescriptions, however on some occasions the incorrect prescriber details were recorded. The pharmacy retained complete CD registers. And of the sample checked, the team kept them in line with legal requirements. The team checked that the physical quantities of CDs matched the balance recorded in the register each week. The inspector checked the balance of a randomly selected CD which was found to be correct. The pharmacy kept complete records of CDs returned to the pharmacy for destruction.

Team members completed mandatory learning on the protection of people's confidentiality and data protection. The team placed confidential waste into a separate container to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. An electrical contractor was working within the dispensary during the inspection and was within proximity of prescriptions and other sensitive data. Team members were not aware if the contractor had completed any confidentiality training or was asked to sign a confidentiality agreement. The importance of this was discussed with the pharmacy manager. All team members completed mandatory learning on the safeguarding of vulnerable adults and children. The pharmacy had a formal procedure to support team members in reporting any concerns identified. They described hypothetical scenarios that they would report. The contact details of the local safeguarding teams were displayed on a notice in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team with the appropriate skills and experience to manage the workload safely and effectively. It takes a structured approach to supporting team members to update their knowledge and skills regularly. Team members are encouraged to provide feedback on the pharmacy's processes to help improve service delivery.

Inspector's evidence

The RP was a relief pharmacist who worked at the pharmacy one day per week. During the inspection they were being supported by the pharmacy's manager who was also a qualified dispenser, a full-time pharmacy dispenser and a part-time trainee pharmacy dispenser. Team members who were not present during the inspection included the pharmacy's full-time pharmacist, a part-time qualified dispenser, and a part-time trainee pharmacy dispenser. Other employees had store-based roles and were not involved in providing pharmacy services. The pharmacy typically had a more team members working on Fridays as this was the pharmacy's busiest day of the week. Throughout the inspection, team members were observed working efficiently. Team members were supporting each other in completing various tasks. They could cover each other's absences by working additional hours if required, however team members explained this was not common as they felt they had enough team members to efficiently manage the workload.

The pharmacy provided each team member with access to its structured training programme to support them in updating their learning and development needs. The programme consisted of mandatory modules for team members to complete, as well as learning following the implementation of a new or reviewed SOP. Team members could choose a module to complete voluntarily following the identification of a learning need. They were provided with protected time to complete their training. This helped team members complete their training without any distractions. Team members engaged in an annual appraisal process. This was in the form of a one-to-one meeting with the pharmacy's manager. Team members discussed their performance and any training needs. For example, a team member who had worked at another pharmacy prior to joining the team explained they wanted to some refresher training on the dispensing process as they had not worked much within the dispensary in their previous role. The team member was supported by working alongside another team member for a period of time until they felt comfortable to dispense without supervision.

Team members attended regular team meetings and topics included patient safety as part of a monthly patient safety review, workload, and other company news. The pharmacy received a monthly professional standards newsletter which contained details of dispensing incidents that had happened at other Boots pharmacies across the UK. Team members discussed these incidents and considered ways they could reduce the risk of similar incidents happening within the pharmacy. For example, they separated medicines that had similar names or packaging to reduce the risk of the incorrect medicine being dispensed. They signed the newsletter to confirm they had read and understood its contents. The pharmacy had a whistleblowing policy and team members were aware of how they could provide feedback or raise a concern. The team had recently implemented a new 'advanced dispensing' process. Team members explained the were initially apprehensive about the process and had provided some feedback to the pharmacy's senior management team about how the process could be adapted to be improved. The team implemented a filing system which helped team members organise the workload

in a more efficient manner. The team was set some targets to achieve. These were based on NHS prescription items and services. Team members explained the targets were generally achievable and they did not feel under any significant pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises is well maintained and suitable for the services provided. The pharmacy has the facilities for people to have private conversations with team members.

Inspector's evidence

The pharmacy was modern, professional in appearance and kept clean and hygienic. A window next to an entrance door was broken. This had been reported to the company maintenance team. The area surrounding the window had been appropriately cordoned to prevent public access. It had a large retail space which held a large variety of toiletries, cosmetics, and other miscellaneous items. The dispensary was located to the side of the retail counter. The dispensary was relatively small but was kept organised throughout the inspection with baskets containing prescriptions and medicines awaiting a final check stored in an orderly manner. There was a separate area used by the RP to complete the final check of prescriptions. This helped reduce the risk of mistakes being made within the dispensing process. There was ample space to store the pharmacy's medicines. The dispensary floor was kept clear of obstruction.

There was a small, soundproofed, consultation room. The room was kept tidy, well organised, and professional in appearance. There was a small office on the ground-floor where the pharmacy kept files and paperwork securely. On the ground floor there was large storeroom. The room was well organised.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services it makes easily accessible to people. The pharmacy team ensures these services are managed safely. The pharmacy mostly stores and secures its medicines appropriately and team members complete regular checks to ensure the medicines are fit for purpose before being supplied to people.

Inspector's evidence

The pharmacy was accessible through automatic doors at street level. Its opening times and the services offered were clearly advertised on the pharmacy's main window and on a display close to the dispensary. The pharmacy had a facility to provide large print labels to people with a visual impairment. Team members described how they supported people with a hearing impairment access the pharmacy's services. They had access to a hearing loop, and they knew how to use it. Several team members were multilingual and supported people by speaking Spanish, German and Romanian. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacy had recently started providing the NHS Pharmacy First service. The pharmacy held the appropriate documentation to provide the services and all team members had undertaken training to support them in managing the service. The RP had access to supportive information including current patient group directions (PGDs), clinical pathways and the service specification to help support the safe delivery of the services. The pharmacy offered the NHS hypertension case finding service. The RP described several cases of where the team had identified people who could benefit from the service and encouraged them to make an appointment to have their blood pressure checked. The RP described a recent consultation with a person who they referred immediately to hospital based on their clinical observations.

An audit trail was in place to identify which team member had entered the data from prescriptions and the identity of the pharmacist who had completed the clinical check of the prescription. Team members described how the process had reduced the time taken to dispense prescriptions and helped the team manage the workload more efficiently. The team used various laminated, coloured, prompt cards to help identify higher-risk medicines such as valproate. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. The RP signed the prescription once a clinical check had been completed. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The baskets were of differing colours to help segregate the workload. For example, blue baskets were used for the delivery service. Team members generated a pharmacist information form (PIF) for each prescription dispensed. The PIF highlighted key information to support the clinical check of prescriptions and the accuracy check of medicines. The pharmacy had recently implemented a new 'advanced dispensing' process. Team members entered data from prescriptions into a digital system. The information entered was checked for accuracy and clinical checked by the pharmacist. The prescription medicines were then ordered. When the prescription stock medicines arrived in the pharmacy, barcode technology was used to match the medicines against the prescription. Prescription labels were printed and applied to the medicines. The medicines stock and labels were scanned, and this provided an additional accuracy check. Prescriptions were then placed on to the retrieval shelves for people to collect. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries.

The pharmacy supplied several people living in their own homes with medicines dispensed in multi-compartment compliance packs. These packs were designed to help people take their medicines at the correct times. The packs were dispensed by team members in a designated area in the storeroom to help reduce distractions from the retail area. Dispensed packs were well organised on shelves. Team members had implemented several steps to help them manage the process safely and effectively. These steps included spreading the workload evenly over four, colour-coded weeks. Prescriptions and 'master sheets' for each person that received a pack were stored in individual, clear wallets. The master sheets had a list of each medicine that was to be dispensed into the packs and times of administration. Team members replaced master sheets to reflect any changes a prescriber may have authorised. For example, if a medicines strength was increased or decreased. The previous master sheet was archived and the date the new master sheet was implemented was recorded. The packs were supplied with patient information leaflets, and some were annotated with descriptions of the medicines inside to help people visually identify them.

The pharmacy stored pharmacy-only (P) medicines directly behind the medicines counter. The pharmacy checked the expiry date of the pharmacy's medicines every three months and kept records of the process. No out-of-date medicine were found following a check of approximately 30 randomly selected medicines. An amber bottle of a medicine that had been removed from its original packaging was found on a dispensary shelf. The bottle was labelled with the name and strength of the medicine, but its expiry date or batch number was not recorded. And so, the team may not have been aware if the medicine had expired or was subjected to a recall. Team members highlighted medicines with short expiry dates using alert stickers. The team marked bulk, liquid medicines with details of their opening dates to ensure they remained fit to supply. The pharmacy used a clinical grade fridge to store medicines that required cold storage. The operating temperature ranges of the fridge were checked and recorded by a team member each day to ensure they were within the accepted range of 2 to 8 degrees Celsius. A sample of the record showed both fridges were operating within the accepted temperature range. Medicines stored in the fridges and CD cabinets were kept well organised. The pharmacy received drug alerts via email. Team members actioned the alerts as soon as possible and kept a record of the action taken to maintain an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

The pharmacy used a range of CE marked measuring cylinders for preparing liquid medicines. There was suitable equipment to support the team to manage the NHS Pharmacy First service and to measure people’s blood pressure. This included an otoscope and several digital blood pressure monitors. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people could not see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people 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.