General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 44 A High Street, Meadowhall Centre, SHEFFIELD, South Yorkshire, S9 1EN

Pharmacy reference: 1039331

Type of pharmacy: Community

Date of inspection: 23/08/2024

Pharmacy context

This is a community pharmacy inside the shopping centre of Meadowhall, in the city of Sheffield. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy offers NHS services such as the NHS blood pressure check service and the NHS Pharmacy First service, and various private services such as a mole scanning service and COVID-19, shingles and chickenpox vaccinations. The pharmacy 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	1.2	Good practice	Team members recognise the importance of recording and reflecting on any mistakes made during the dispensing process and they are good at identifying trends or patterns in the records and implementing changes to the way they work to manage risks.
2. Staff	Standards met	2.1	Good practice	The pharmacy reviews and implements changes to its staffing profile in response to changes in its workload. For example, when new services are introduced.
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 keeps people's sensitive information secure. Team members recognise the importance of recording and reflecting on any mistakes made during the dispensing process and they are good at identifying trends or patterns in the records and implementing 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 ensuring extra care was taken when dispensing medicines that were manufactured in different pack sizes and ensuring the pharmacy's CD cabinet was kept well organised to support the team with accurate supply of CDs to people.

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. Team members described feedback as being wholly positive

and were not aware of any recent complaints or negative feedback.

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 records of supplies against private prescriptions. Most of the private prescriptions dispensed by the pharmacy were from the Boots Online Doctor service. Records were generally kept correctly however on some occasions, the place of practice of the Boots Online Doctor service prescriber was recorded as the pharmacy. This was incorrect and the importance of recording the correct place of practice of the prescriber was discussed with the team. 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. 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 reviews and implements changes to its staffing profile in response to changes in its workload. For example, when new services are introduced. The pharmacy 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 during the inspection was a locum pharmacist. The RP was being supported by two other pharmacists, the store manager, three part-time qualified dispensers, two part-time qualified medicines counter assistants (MCAs) and a trainee MCA. Team members who were not present during the inspection included the pharmacy's manager who was also a qualified dispenser, two part-time pharmacists, a part-time accuracy checking pharmacy technician (ACPT), three part-time qualified dispensers, a part-time qualified MCA and three MCAs who had completed additional training to manage the internal Boots role of 'Healthcare Specialist'. The role of healthcare specialist had been introduced since the pharmacy refitted the it's retail area to allow the selection of Pharmacy (P) medicines. Other employees had store-based roles and were not involved in providing pharmacy services. Team members describe how the pharmacy had seen a significant increase in the number of consultation-based services it was providing. To respond to this change, the pharmacy completed a review of its staffing profile. The pharmacy altered the profile to ensure it had three pharmacists working during the pharmacy's busiest times of business. One pharmacist spent most of their shift completing consultations while other team members were managing the dispensing workload. The pharmacy was busy throughout the inspection; however, team members were observed working efficiently and supporting each other to complete 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. Following recent appraisals, several team members had trained to qualify for the role of healthcare specialist.

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. The pharmacy had a whistleblowing policy and team members were aware of how

they could provide feedback or raise a concern. The team implemented an updated 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 consultations with team members.

Inspector's evidence

The pharmacy was at the rear of the retail store. The store was large and stocked a significant range of healthcare and non-healthcare related products. The pharmacy had undergone a significant refit at the beginning of the year. It was modern, professional in appearance and kept clean and hygienic. The dispensary area 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 waiting area located close to two consultation rooms. The area had several sofa chairs and a coffee table to support people to be comfortable while they were awaiting a prescription to be dispensed or to be called for their appointment for a consultation. The two consultation rooms were kept tidy, well organised, and professional in appearance. There was a small office where the pharmacy kept files and paperwork securely. There was large storeroom which 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 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 the main shopping centre. Its opening times and the services offered were clearly advertised 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 via a hearing loop. Several team members were multilingual and supported people by speaking Urdu and Punjabi. 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. It held the appropriate documentation to provide the services and all team members had undertaken training to support them in managing the service. The team 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 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 pharmacy held the correct documentation for each of the private services it provided. All consultations for the services were arranged via an appointment system. Appointments were booked via the Boots website or through a team member in the pharmacy. The mole screening service had become increasingly popular over the calendar year. A pharmacist described an occasion where a person's had been appropriately referred to a cancer clinic following a consultation at the pharmacy.

An electronic 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 plastic tubs and trays to hold prescriptions and medicines together which reduced the risk of them being mixed up. 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.

Following the pharmacy's refurbishment, the pharmacy had moved from storing P medicines behind the medicines counter, to storing them on open shelves which made them available for people to select themselves. There were three till stations located in close vicinity to where the P medicines were stored. Team members working at these stations supported people to choose a suitable medicine to manage their health. P medicines were only able to be sold at these tills. A team member demonstrated when the barcode of a medicine was scanned for sale at another till within the store, an alert was displayed to remind the team member that the medicine could only be sold at the pharmacy. This helped reduce the risk of a medicine being sold by a non-pharmacy team member. Team members described how people often wished to purchase non-pharmacy products at the pharmacy till stations along with any P medicines they had chosen. Team members agreed that when people had a significant number of products to purchase, this increased the risk of a team member scanning a P medicine without noticing and therefore being unable to ask the person appropriate screening questions to ensure medicines were supplied safely. 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. 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 clinical grade fridges to store medicines that required cold storage. The operating temperature ranges of the fridges 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 the 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 mole scanning machine was regularly serviced. There were adrenaline injections, alcohol wipes and sharps bins kept in both consultation rooms to support the team to provide vaccinations.

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.