General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 50 Manor Park Centre, SHEFFIELD, South Yorkshire, S2 1WE

Pharmacy reference: 1086523

Type of pharmacy: Community

Date of inspection: 15/01/2020

Pharmacy context

This is a community pharmacy next to a small GP surgery on a parade of shops close to the city centre of Sheffield. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service and medicines use reviews. The pharmacy provides a substance misuse service. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service.

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	2.2	Good practice	The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.
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 the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They discuss how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a small retail area which led to the dispensary at the rear of the building. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The retail area and the dispensary were open plan which allowed the team members to easily see into the retail area from the dispensary. The dispensary was set back far enough from the pharmacy counter to allow the team members to discuss confidential matters without being overheard by people in the retail area. The pharmacist used a bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed her to easily oversee any sales of medicines and listen to any advice the team members were giving to people.

The pharmacy had a set of written standard operating procedures (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. Some of SOPs had documented review dates of August and November 2019. For example, the controlled drugs (CDs) SOPs. There were some newer SOPs that had replaced these older ones. But they were not stored in the correct place in the SOP file. So, it may be difficult for the team members to easily refer to the most up-to-date SOP for some processes. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role. And they completed a short quiz sheet when they had been issued with new or revised SOPs to test their understanding.

The pharmacist and accuracy checking technician (ACT) highlighted near miss errors made by the team when dispensing. And the details of each near miss error were recorded onto a paper near miss log. The team members recorded the date, time and type of the error. But they did not record the reasons why the error may have happened in much detail. And so, they may have missed out on some learning opportunities. The team members said that their main reason for errors was because of a lack of concentration or rushing. But they did not investigate these reasons any further. The pharmacy appointed a team member to be the pharmacy's patient safety champion. The role of the team member was to analyse the near miss records each month for any patterns and trends. And to discuss any findings with the team in a monthly patient safety briefing. The team agreed actions to complete following each analysis. And they assessed success of those actions at the next briefing. The pharmacy had recently had new dispensing software installed. The new software required the team members to scan the barcodes of each item while they were dispensing. And the software would alert the team member if the wrong item had been selected. The team members explained the system had reduced the number of near miss errors they made. But they were still making some quantity errors. To help

them improve, the team members decided they would always highlight the quantity on the packaging of the medicine using a marker pen to help remind the pharmacist to carefully double check the quantity during their final checking process. The pharmacy had a process to record and report dispensing incidents that had reached the patient. It recorded the details of such incidents using an electronic reporting system called PIERS. A sample of some records were seen. Within the sample the team had recorded the full details of the error, who had been involved, why the error might have happened and what the pharmacy did to prevent a similar error happening again. Most recently, the pharmacy had supplied a person with the incorrect medicine. The team members discussed the incident during a patient safety briefing, and they considered ways they could prevent a similar incident happening again. A pop-up alert was added to the person's electronic medication record (PMR), which was displayed on the computer screen each time the person's record was accessed. The alert reminded the team members of the error so they could take extra care when dispensing.

The pharmacy used small paper slips called pharmacist information forms (PIFs). They were used to communicate messages to the pharmacist such as if a person was eligible for a service. Or if there were any changes in dose or directions. The team members also used the forms to inform the pharmacist if the medicines being dispensed were look-alike or sound-alike (LASA) medicines and were therefore at a higher risk of being involved in an error. The pharmacy had a list of the most common LASA medicines attached to each workstation. It also had 'select and speak' stickers attached to the shelves in front of several LASA medicines. The stickers were designed to encourage the team members to 'speak' the name of the medicine before they selected it. The stickers had the middle of the name of the medicine written in capital letters to help the team members make a clear distinction between the two medicines. For example, amLODipine and amiTRIPtyline.

The pharmacy displayed the correct responsible pharmacist notice. But it was not easily seen from the retail area. And so, people may not have been able to see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist. The ACT was seen completing accuracy checks on prescriptions that had been clinically checked by the pharmacist. The team members used a stamp split into four sections to record which team member had accuracy checked the prescription, clinically checked the prescription, dispensed the medicines and handed out the medicines. This ensured the pharmacy kept a robust audit trail of dispensing activities.

The pharmacy had a formal complaints procedure in place. And details were available for people to see in the pharmacy's practice leaflet which was available in the retail area for self-selection. The pharmacy collected feedback through an annual patient satisfaction survey. The team members discussed the findings of the survey with each other. But they were unable to give any examples of improvements made to the pharmacy following the feedback.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team was aware of the need to keep people's personal information confidential. And team members were seen offering the use of the consultation room to people or moving to a quieter area of the retail area, when discussing their health. They had all undertaken General Data Protection Regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The pharmacist and the ACT had completed training on safeguarding via the Centre for Pharmacy Postgraduate Education (CPPE). And when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams. Recently, the team members had concerns about the ability of a vulnerable person to take their medicines correctly. They contacted the person’s GP and telephoned the person every week to check they were taking their medicines correctly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. And they feel comfortable to raise professional concerns when necessary. The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the pharmacy manager who had been working at the pharmacy for around two years. She was supported by a full-time ACT, a part-time NVQ level 2 pharmacy assistant and a full-time NVQ level 2 pharmacy assistant. Each of the team members present during the inspection had been working at the pharmacy for several years and knew many of the people who used the pharmacy by their first names. The pharmacy's dispensing volume had recently increased. And so, the pharmacy's staffing rotas had been reviewed. Following the review, a pharmacy assistant increased the number of hours she worked. This ensured the pharmacy was appropriately staffed during busier times of day. The pharmacist felt she had enough team members to ensure the pharmacy provided a high quality of service. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The pharmacy provided the team with support if the ACT was absent. The pharmacy employed a part-time pharmacist to work on the days the regular pharmacist was absent. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules. The modules covered various topics, including mandatory compliance training covering health and safety and information governance. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. They could also take the opportunity to give feedback to improve the services the pharmacy offered. A team member explained how she had identified that the team didn't always take people's telephone numbers. She had provided feedback about this to the team. So, people could receive text messages when their medicines were ready. And this would improve the quality of service they received.

The team members felt comfortable to raise professional concerns with pharmacist or the pharmacy's area manager. The pharmacy had a whistleblowing policy. And so, the team members could raise

concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was small, but it was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. The team members identify people taking high-risk medicines. And they support them to take their medicines safely and give them appropriate advice.

Inspector's evidence

The pharmacy had level access from the street. The entrance door was power assisted. And so, people with prams and wheelchairs could enter the pharmacy unaided. The pharmacy advertised its services and opening hours in the main window and on the pharmacy's website. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets about winter health, smoking cessation and mental wellbeing. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services. The pharmacy could supply people with large print dispensing labels if needed.

The team members regularly used various laminated cards during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. The pharmacy had clearly marked shelves which were used to store prescriptions in baskets that were awaiting a final check. And there were separate shelves used to store prescriptions in baskets that were awaiting stock before being completed. They used 'CD' laminated cards to keep with prescriptions. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The pharmacy managed the workload across four weeks. The team was responsible for ordering people's prescriptions. And this was done in the third week of the cycle. Which gave the team members a week to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in a segregated part of the dispensary. This was to minimise distractions. And they kept all documents related to each person on the service in separate wallets. The team members used progress charts. The charts helped the team visually assess the progress of the dispensing. The

documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. The team members held all prescriptions, documents and stock in separate baskets during the dispensing process. And they used shelves to store the baskets. The shelves were marked as 'awaiting assembly' or 'awaiting check'. The team members used 'communication record' slips to record details of conversations they had with people's GPs. For example, if they were notified of a change in directions, or if a treatment was to be stopped. They supplied the packs with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs. The team used collection dockets. These were used to record the date when a pack was handed out. And the person collecting the packs was required to sign the docket confirming they had taken receipt of the pack.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used separate laminated cards. They kept these with people's prescriptions as a reminder to discuss the person's treatment when handing out the medicine. There were example questions on the reverse of the cards to remind the pharmacist to ask the person collecting various questions to make sure they were taking their medicines safely. For example, the pharmacist asked for the persons current and target INR, their daily dosage and the date of their next blood test. The pharmacist recorded the INR levels on the person's electronic medication record (PMR). The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified.

Pharmacy medicines (P) were stored in glass cabinets at the side of the pharmacy counter. The cabinets were not kept locked. The pharmacy did not always have a team member working on the pharmacy counter or in the retail area. And the team members explained this made it difficult for them to stop anyone from opening the cabinet and selecting medicines. They had recently affixed a notice on the door of the cabinets. The notice explained to people that the medicines inside the cabinet were not for self-selection. And to ask a team member for assistance. But the team members said many people did not adhere to the notice. And so, they tried to listen for the sound of the door being opened. And they would then come out of the dispensary and assist the person.

The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next 12 months. They kept records of which medicines were expiring in each month. At the beginning of the month, they referred to the records and removed any of the medicines stored in the dispensary. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The

pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were separate cylinders used to dispense methadone. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the 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.