General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 36-40 Broadwalk, DUNSTABLE, Bedfordshire, LU5 4RH

Pharmacy reference: 1028821

Type of pharmacy: Community

Date of inspection: 11/07/2022

Pharmacy context

The pharmacy is in a town centre. It provides NHS and private prescription dispensing mainly to local residents. The pharmacy provides a supervised consumption service for people treated by the drug and alcohol team. It provides flu vaccinations in season, malaria prevention treatment via an on-line pharmacist prescriber and emergency hormonal contraception under a PGD. Some people are provided with medicines in multi-compartment compliance packs.

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. The team members are clear about their roles and responsibilities. They log mistakes they make during the pharmacy processes. And they learn from these to avoid problems being repeated. The pharmacy keeps its records up to date to show that it is providing safe services. It manages and protects people's personal information well. The team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that were offered by the pharmacy. The pharmacy's team members said they read them. The procedures said the team members should log any mistakes in the dispensing process in order to learn from them. Dispensing mistakes that had not reached a person were called 'near misses'. They regularly logged any issues, now using a computer-based system and had a monthly meeting to discuss trends and learning from these near misses. Medicines which looked alike or had similar names were separated on the shelves. There was a monthly meeting to discuss trends and learning from the near misses, where mistakes were made but identified before the items were handed to the patient.

The pharmacy conspicuously displayed the correct responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice, when needed. Feedback was sought from customers about the service they received.

The pharmacy team recorded private prescriptions and emergency supplies as required by law. The controlled drugs registers seen were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries.

Information produced by the computers and labelling equipment was not visible to people in the retail area. Computers were password protected to prevent unauthorised access to confidential information. Other patient-identifiable information was kept securely away from the public view. Confidential waste was separated into bags and disposed of by a licensed waste contractor. Access to the NHS database was robust, with staff seen to remove their access cards when not using the computers.

The pharmacist had undertaken level 2 training on safeguarding and the whole team had done internal training on the subject. There were local telephone numbers for the safeguarding boards available for use if needed. The pharmacy had current professional indemnity and public liability insurances.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe services. Staff do ongoing training to help keep their skills and knowledge up to date.

Inspector's evidence

There was a relief pharmacist and two dispensers working in the pharmacy on the day of the inspection. One of the dispensers was training for that role, the other had completed their training. The regular pharmacist was off on maternity leave and the pharmacy was being covered mainly by regular relief staff. One dispenser dispensed prescriptions, and the other dispenser was dealing with dispensing on the front counter. There were three other part-time trained dispensers and one full-time one, who were not present on the day of the inspection.

Staff were given time for training and said that they were up to date with this. Topics covered had included general subjects such as safeguarding, mental health and well-being as well as timely reminders such as hayfever treatments. They had regular appraisals and said that they were well supported by the management team and were able to make suggestions about changes to processes in the pharmacy. The team described verbal feedback that was provided about past performance. They said that the manager was receptive to improvements and suggestions. Team members said that they felt that the targets were achievable. They said that they did not feel any undue pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The shop area was large and the dispensary was to one side. The dispensary was clean, bright, tidy and well ordered, with separate areas for dispensing and checking. Multi-compartment compliance packs were dispensed in the dispensary on a dedicated bench. The shelving was in good order and suitable for the stock. There was a consultation room adjacent to the dispensary. And the queue for the chemist counter and dispensary were managed to provide some assurance regarding COVID-19 transmission. The premises were kept secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are largely safe and effective, and it gets its medicines from reputable sources. The pharmacy responds appropriately to safety alerts so that people get medicines and medical devices that are safe to use. The pharmacy does not always highlight prescriptions for higher-risk medicines. So, it may be harder for it to identify people taking these medicines and provide them with all the advice they need to take their medicines safely.

Inspector's evidence

Access to the pharmacy was level from the pavement. Services were advertised in the windows. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another. Computer-generated labels included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. Medicines were delivered by a dedicated driver, who kept records of where they had delivered to.

Schedule 4 controlled drug prescriptions were not always highlighted to staff who were to hand them out. This could increase the chance of these items being handed out more than 28 days after the date on the prescription.

Prescriptions for warfarin, lithium or methotrexate were sometimes flagged by the pharmacists, and then staff would ask people about any recent blood tests or their current dose. But if the pharmacists did not flag the prescription, the staff would not always notice the medicine and ask the appropriate questions. So, it could be harder for staff to identify these people and provide them with the appropriate advice. People in the at-risk group who were receiving prescriptions for valproate were routinely counselled about pregnancy prevention. And appropriate warnings stickers were available for use if the manufacturer's packaging could not be used.

Some people were being supplied their medicines in multi-compartment compliance packs. These packs were labelled with the information the person needed to take their medicines in the correct way. The packs also had tablet descriptions to identify the individual medicines contained in the packs. Patient information leaflets (PILs) were supplied, meaning that people could easily access the information provided by the manufacturer about their medicines. There was a summary sheet in the pharmacy for each person receiving these packs showing any changes to their medicines and where the medicines were to be placed in the packs. Each patient was being assessed by telephone for the need to dispense in multi-compartment compliance packs. Those people who still needed the packs were supplied with them. Other adjustments were made for other people.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. Fridge temperatures were recorded daily and were within the recommended range. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with cytotoxic tablets ensuring that dust from them did not cross-contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment was regularly tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.