General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 197-199 High Street, CHELTENHAM, Gloucestershire, GL50 1DB

Pharmacy reference: 1031492

Type of pharmacy: Community

Date of inspection: 10/09/2024

Pharmacy context

This is a community pharmacy located in in the centre of Cheltenham, Gloucestershire. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines, and provides health advice. It also offers the New Medicine Service (NMS), local deliveries and Pharmacy First. Its team members provide multi-compartment compliance packs for some people who find it difficult to manage their medicines at home. And the pharmacy supplies medicines for residents 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 regularly reviews and monitors the safety and quality of its services.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake.
		2.4	Good practice	The pharmacy has an environment where learning and development for team members is supported and encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy's services are managed and delivered safely and effectively.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is operating in a safe and effective manner. It has suitable systems in place to identify and manage the risks associated with its services. Members of the pharmacy team monitor the safety of their services by recording their mistakes and learning from them. They understand their role in protecting the welfare of vulnerable people. The pharmacy protects people's confidential information appropriately. And the pharmacy generally maintains its records as it should.

Inspector's evidence

Members of the pharmacy team understood their roles well and they knew what they could or could not do in the absence of the responsible pharmacist (RP). This included the newest member of staff. The team routinely worked in accordance with the company's current standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The accuracy checking technician (ACT) was also the pharmacy's patient safety lead (see below). She was very enthusiastic about ensuring internal processes were safe. After staff, including the store manager had read new SOPs or updates, they were then assessed by the ACT on the knowledge gained and practice. This helped ensure the team worked in line with and enforced internal standards.

The pharmacy supplied several care homes with medicines for their residents and they had documented service agreements in place with the pharmacy to define the relationship and terms between them. Once prescriptions had been assembled for the care homes, the ACT usually carried out the final accuracy-check. Before this task was undertaken, the RP clinically checked the prescription(s), medication administration records (MAR) and any associated information first, before other staff assembled it. The clinical check was marked on the prescription using the quadrant stamp which helped identify that this stage had been completed. The ACT confirmed that she was not involved in any other dispensing process other than the final check, and there was an SOP to cover this process.

Staff described concentrating on each person's prescription as they assembled them. They ensured suitable checks were made between the details on prescriptions, generated dispensing labels, medicines and MARs during the assembly process. Team members worked in different areas and the pharmacists as well as the ACT accuracy-checked prescriptions from designated areas. This helped minimise distractions. Staff rotated tasks when they assembled medicines for the care homes and distractions were limited where possible so during certain tasks, staff did not answer the phone to avoid losing focus in the process they were undertaking at that time. In addition, some of the pharmacy's processes were automated with bar code scanning technology being used. This helped minimise the risk of selection errors and had made internal processes more efficient.

Errors that occurred during the dispensing process (near miss mistakes) were routinely passed back to staff for them to identify and record. The ACT reviewed the details every week, collated and recorded them as well as subsequently feeding them back to the team. Staff described trends recently being seen with quantities and counting errors. Staff were subsequently writing the quantity counted on the inside of the boxes of medicines which was checked at the accuracy checking stage. This had helped reduce the number of errors being made.

The pharmacy also had appropriate complaints and incident management processes in place. The

pharmacy displayed details about how people could make a complaint or provide feedback and pharmacists as well as the store manager described handling incidents and complaints in a suitable way. This included investigating the situation, identifying the root cause, implementing changes, and reporting the details to the superintendent pharmacist (SI).

The pharmacy's team members had been trained to protect people's confidential information. Details were on display in the retail area explaining the pharmacy's privacy policy. The team used their own NHS smart cards to access electronic prescriptions. Confidential waste was separated and disposed of appropriately and there was no sensitive information visible from or left in the retail area. Pharmacists were trained to level three, the ACT to level two and the rest of the team to level one to safeguard the welfare of vulnerable people. Members of the team could recognise signs of concern and knew who to refer to in the event of a concern. Contact details for relevant agencies were readily accessible.

The pharmacy had suitable professional indemnity insurance arrangements in place. Most of the pharmacy's records were compliant with statutory and best practice requirements. This included a sample of electronic registers seen for CDs, the RP record and electronic records of supplies made against private prescriptions. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had been maintained and records verifying that fridge temperatures had remained within the required range had been completed. However, unclear abbreviations were sometimes used to record the nature of the emergency when a supply of a prescription-only medicine was made, in an emergency without a prescription. This could make it harder for the pharmacy to justify the supplies made. This was discussed at the time. In addition, the inspection took place in the afternoon and an incorrect notice to identify the pharmacist responsible for the pharmacy's activities was on display. This was rectified by the locum pharmacist when highlighted.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has enough appropriately skilled staff to deliver the pharmacy's services. Members of the pharmacy team have a range of skills and experience. And the pharmacy provides them with sufficient support as well as the resources they need, so that they can complete regular and ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

On the day of the inspection, staff present included two locum pharmacists, a pharmacy technician and a trained dispenser currently undertaking accredited training to level three in the dispensary situated downstairs. This team served people on the counter and dealt with people who brought in prescriptions as well as repeat prescriptions. A different team was situated in the dispensary upstairs, staff prepared medicines for care homes and multicompartment compliance packs here. During the inspection, this team included the ACT, the care home supervisor who was also a trained dispenser and two further trained dispensers. The store manager was also present who was also a trained dispensing assistant. Some members of the team were off-sick or on leave and the pharmacy was currently being run on locums or relief pharmacists. The pharmacy team covered each other, staff upstairs came down as contingency for the team downstairs if needed and the pharmacy team was up to date with the current workload.

Staff wore name badges and uniforms. They worked well together. The inspector observed and staff described a positive rapport as well as a supportive working environment. Many of the team were long-standing as well as being experienced members of the team. Some had received loyalty awards from the company for the time that they had worked at the pharmacy. Staff were kept informed about changes or updates through regular team meetings and briefings, they could easily raise concerns if needed and they could make suggestions about how to improve internal processes. They were also aware of the company's whistleblowing policy and where to access contact details if this was needed.

Staff asked an appropriate range of questions before selling medicines and they referred appropriately. The company supported the team to progress and develop training further; formal performance reviews took place annually. Team members in training were provided with protected time to complete accredited training at work. Staff were also provided with resources for ongoing training through the company's e-learning platform and a suite of available resources. This included Professional Standards newsletters or bulletins. The store manager confirmed that the team was up to date with mandatory training such as health and safety, safeguarding and information governance.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean, it is secure, and professionally presented. And it has separate areas where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises were inside a large retail store, which was professionally presented with modern fixtures and fittings. The premises included a spacious retail area, two consultation rooms, two dispensaries, one of which was upstairs, staff areas as well as a section to store medicines and stock. Both dispensaries were of a suitable size and enabled staff to carry out dispensing tasks safely. The dispensary on the ground floor was also screened which provided a suitable level of privacy when dispensing prescriptions. The consultation rooms were kept locked when not in use, the one used by the pharmacy team was small but adequate for its intended purpose. The pharmacy was clean, very tidy, and organised. The premises were bright and suitably ventilated. The ambient temperature was suitable for the storage of medicines and the pharmacy was secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has safe working practices. People can easily access the pharmacy's services. The pharmacy provides medicines to people in care homes and inside multicompartment compliance packs safely. Team members identify people with higher-risk medicines so that they can provide the appropriate advice. This helps ensure they take their medicines correctly. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well.

Inspector's evidence

People could enter the pharmacy from the street which was step free. The store retail area consisted of different levels, but it had clear, open space and wide aisles as well as lifts and escalators. This helped people with restricted mobility or using wheelchairs to access the pharmacy's services. There were a few chairs inside the pharmacy if people wanted to wait for their prescriptions and the pharmacy's opening hours were on display. Staff could make suitable adjustments for people with diverse needs, they offered a separate area or the consultation room when required, provided details verbally or in a suitable written format, could print details using a larger sized font and a hearing induction loop was available if needed.

The workflow involved the team using plastic tubs to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. After the staff had generated the dispensing labels for the medicines for the care homes, there was a facility on them which helped identify who had been involved in the dispensing process. Team members signed the quadrant stamp printed on every prescription which helped identify who was responsible for dispensing, accuracy checking, clinical checking and handing the prescription out. Staff routinely used these as an audit trail. During the accuracy-checking process, electronic pharmacist information forms (PIFs) were printed and completed which ensured that a clinical check of the prescription occurred and identified relevant points. This helped staff to counsel or advise people on how to take their medicine(s) appropriately.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. They were stored in an organised way. The team date-checked medicines for expiry regularly and kept records of when this process took place. Short-dated medicines were identified and there were no date-expired medicines seen. Liquid medicines, when opened were marked with the date they were opened. This helped to determine stability when dispensing them in the future. CDs were stored securely and the keys to the cabinet were maintained in a way which prevented unauthorised access. Dispensed medicines requiring refrigeration were stored within clear bags. This helped to easily identify the contents upon hand-out. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This included sharps or needles provided they were in sealed bins. Drug alerts were received by email and actioned appropriately. Records were kept verifying this.

Team members were aware of the risks associated with valproates, they ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them and had identified people in the at-risk group who had been supplied this medicine. Appropriate literature was also available to provide to people at risk when supplying valproates. People prescribed other higher-risk medicines were routinely identified, upon-handing out these medicines, staff were

prompted by the pharmacy system to ensure relevant questions or details about their treatment were asked and this information was routinely recorded.

The care homes ordered repeat prescriptions for their residents, and the pharmacy's system enabled it to track and monitor this. A summary form of missing items was generated for the team to use to support the homes if needed. Staff monitored the process, and schedules were in place to help keep track of when the medicines were due. Team members obtained information about allergies and recorded this on the medication administration record (MAR). The team was also provided with relevant details for residents who required higher-risk medicines and this information was retained. Interim or medicines which were needed mid-cycle were dispensed at the pharmacy. Any requests to administer medicines covertly required supporting documentation and authorisation from the person's GP; records of advice provided by the pharmacist were kept and suitable reference sources used. Patient information leaflets (PILs) were routinely supplied. Relevant details about drug alerts and serious shortage protocols (SSPs) were provided to the care homes and checked during pharmacist support visits. The supervisor for the care home section also attended these visits.

The pharmacy also provided people who lived in their own homes with their medicines inside compliance packs once a need for this had been identified. The team ordered prescriptions on behalf of people and kept schedules to highlight when various stages in the process had been completed. Staff identified any changes that may have been made, maintained individual records to reflect this and queried details if required. All the medicines were de-blistered into the compliance packs with none supplied within their outer packaging. The compliance packs were sealed as soon as they had been prepared. Descriptions of the medicines inside the compliance packs were provided and patient information leaflets (PILs) were routinely supplied.

The pharmacy offered a delivery service, and the team kept records about this service. Failed deliveries were brought back to the pharmacy, people were called beforehand to inform them about the delivery and medicines were not left unattended.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Its equipment is suitably clean. And team members use them appropriately to keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was suitable and kept very clean. Both dispensaries held the appropriate range of equipment needed to dispense medicines safely. This included standardised conical measures for liquid medicines and triangle tablet counters as well as separate ones which were marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy also had appropriately operating pharmacy fridges, legally compliant CD cabinets, current reference sources, access to hot and cold running water as well as clean sinks. Portable telephones helped conversations to take place in private if required. The pharmacy's computer terminals were password protected and their screens faced away from people using the pharmacy. This helped prevent unauthorised access.

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.