General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 122-126 High Street, NEWPORT, Isle of Wight, PO30 1TP

Pharmacy reference: 1032534

Type of pharmacy: Community

Date of inspection: 24/10/2022

Pharmacy context

This is an NHS community pharmacy located in the town centre of Newport, Isle of Wight. The pharmacy is open seven days a week. And it sells a range of health and beauty products, including over-the-counter medicines. It dispenses people's prescriptions and provides medicines for patients in care homes. The pharmacy also provides NHS and private flu vaccinations.

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 manages its risks. It has written procedures in place to help its team work safely. It keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they talk to each other about the mistakes they make. So, they can learn from them.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these had been reviewed and the pharmacy team had read and signed them to show they understood them and would follow them. The pharmacy had processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Members of the pharmacy team were required to record near misses and dispensing errors electronically. They reviewed and discussed the mistakes they made, so they could learn from them. And, for example, a review of the dispensing, checking and handing out process had been carried out and strengthened following an incident involving the handing out of the wrong strength of a controlled drug.

The pharmacy had considered the risks of COVID-19. Occupational risk assessments for individual team members had been completed during the pandemic. The pharmacy had plastic screens on its counters to try and stop the spread of the virus. Team members had the personal protective equipment they needed as well as hand sanitising gel.

Members of the pharmacy team wore name badges which identified their roles within the pharmacy. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were also described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist.

The pharmacy had a complaints procedure. And in-store leaflets asked people to share their views and suggestions about how the pharmacy could do things better. The pharmacy had appropriate insurance arrangements in place for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was that was working. It recorded the emergency supplies it made and the private prescriptions supplied. The pharmacy recorded controlled drugs supplied in the appropriate register as well as recording running balances and patient returned controlled drugs. The pharmacy kept a record for the supplies of the unlicensed medicinal products it made.

People using the pharmacy couldn't see other people's personal information. The pharmacy had arrangements to make sure confidential information was stored and disposed of securely. And it had policies on information governance and safeguarding. Members of the pharmacy team had completed

safeguarding training relevant to their roles and training on information governance. They could refer to the pharmacy's safeguarding policy to help them if they wanted to raise a safeguarding concern. And they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team do the training needed to do their jobs safely. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one.

Inspector's evidence

At the time of the inspection the pharmacy had three pharmacy advisors and a pharmacist working in the main dispensary, together with a locum pharmacist and two technicians working in the care home hub upstairs and an additional locum pharmacist providing flu vaccinations. Staff could be moved between the pharmacies within the group on the island in the case of emergencies and to make sure each had enough of the right people working at the right time to provide safe and effective care. The team worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The team was observed asking the necessary questions when making over-the-counter recommendations and referring to the pharmacist when necessary for advice, for example in relation to people who were pregnant.

The team members were encouraged to complete online training when the pharmacy wasn't busy to make sure their knowledge was up to date. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable and secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy had a main dispensary area together with a separate dispensary area upstairs where prescriptions for care homes and compliance aids were prepared in private. Fixtures and fittings were appropriate for the service provided and the pharmacy was clean with sufficient space and presented in a professional manner. There were sinks available in the dispensary areas with hot and cold running water with sanitiser to allow for hand washing. The consultation room was clean and kept locked when not in use.

The ambient temperature and lighting throughout the pharmacy was controlled by air-conditioning units and appropriate for the delivery of pharmaceutical services

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are safe and effective. And its team is friendly and tries to help people access its services. Members of the pharmacy team dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely.

Inspector's evidence

The pharmacy's opening hours were listed on the front door, and it had notices and leaflets that told people about the services it delivered. Members of the pharmacy team were friendly and helpful, and they took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy. The team members responsible for making up people's prescriptions kept the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They scanned the bar code of the medication they selected to check they had chosen the right product. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the RP who also initialled the dispensing label.

The pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used clear bags for some dispensed items, such as CDs and insulins, to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy team used reminder cards and notes to highlight when a pharmacist needed to speak to the person about the medication they were collecting. For example, higher-risk medication, or if other items, such as a CD or a refrigerated product, needed to be added.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Team members checked the expiry dates of medicines at regular intervals and they marked and highlighted products which were due to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs securely.

The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. The pharmacy keeps its equipment clean and uses its facilities appropriately to protect people's privacy.

Inspector's evidence

The pharmacy had a range of suitable glass measures to measure out liquids correctly. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And they could contact the Chief Pharmacist's office to ask for information and guidance.

The pharmacy positioned its computer screens so these could only be seen by a member of the pharmacy team. It restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password.

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.