General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 29 Oaten Hill, CANTERBURY, Kent, CT1 3HZ

Pharmacy reference: 1032662

Type of pharmacy: Community

Date of inspection: 27/03/2024

Pharmacy context

The pharmacy is on a busy street near Canterbury city centre. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. It supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people.

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 records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
2. Staff	Standards met	2.2	Good practice	The pharmacy gives its team members time set aside to do training. It encourages them to complete the training at work. And this helps them keep their knowledge and skills up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy services are well managed with a clear focus on patient safety.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages the risks associated with its services well and provides them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information well. And it largely keeps its records up to date and accurate. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. And their roles and responsibilities were specified in the SOPs. The pharmacy manager (a trained dispenser) said that the pharmacy would remain closed if the pharmacist had not arrived in the morning. And she would contact the pharmacy's head office. She mentioned that a local pharmacy in the company could provide short-term temporary cover if needed. The pharmacy would display a notice at the main entrance showing the estimated time the pharmacy would open. The pharmacy manager knew that team members should not hand out dispensed medicines or sell pharmacy-only medicines if the pharmacist was not in the pharmacy.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying it. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the patient safety reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacy manager said that most of the mistakes involved the wrong quantity being dispensed. She said that team members were asked to finish dispensing a prescription before answering the phone or attending to people at the counter, to reduce the risk caused by interruptions. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where a medicine had been supplied to the wrong person. The pharmacy manager said that team members had been reminded to check the person's details on each prescription against the bag label and initial it to show that they had done this. The bag label was also initialled when the items were handed out to show that it had been checked against the prescription again.

Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. Plastic tubs were used to minimise the risk of medicines being transferred to a different prescription. And workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload.

The pharmacy had current professional indemnity insurance. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any liquid overage was recorded in the register. The right responsible pharmacist (RP) notice was clearly

displayed, and the RP record was completed correctly. The private prescription records were largely completed correctly, but the correct prescriber details and the appropriate date on the prescription were not routinely recorded. The nature of the emergency was not always recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacy manager said that she would ensure that the private prescription record and emergency supply record were completed properly in future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People’s personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet and on the pharmacy’s website. The pharmacy manager said that there had not been any recent complaints. She would attempt to deal with the complaint in the pharmacy and would inform the area manager or pharmacy’s head office if she was not able to.

Team members (including the delivery driver) had completed training about protecting vulnerable people. The pharmacy manager described potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist. The pharmacy manager gave an example of action the pharmacy had taken in response to a recent safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one relief pharmacist and two trained dispensers (one was also the pharmacy manager) working during the inspection. The pharmacy manager explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. Team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

The pharmacy manager appeared confident when speaking with people. And she asked questions to establish if a medicine was suitable for the person it was intended for. She knew which over-the-counter medicines could be abused or may require additional care. And she would refer to the pharmacist if a person regularly asked to purchase one of these medicines. She was also aware of the restrictions on sales of medicines containing pseudoephedrine.

Team members did regular mandatory training for things like manual handling, data protection and fire safety. They also read the updated SOPs and this activity was recorded. Team members could access the pharmacy's online training portal on their phones or on a computer. They were allocated weekly protected training time, but they could also access the training modules at home if they preferred. Team members had recently completed training for the Pharmacy Quality Scheme and the Pharmacy First service. The pharmacy manager and the area manager monitored training and the pharmacy was notified if training had not been completed within the required timeframe. The pharmacy manager explained that team members would be supported if they wanted to do further education. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And he felt able to make professional decisions. He had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacy had regular informal meetings to allocate tasks and discuss any issues. The pharmacy's head office produced a newsletter highlighting common themes throughout the company. The pharmacy manager said that the area manager regularly visited the pharmacy, and she could contact her if there were any issues or concerns. The pharmacy attended twice weekly conference calls with the area manager and local pharmacies in the group. The pharmacy manager said that matters such as targets, ongoing issues and training were discussed during the calls. Team members had yearly performance reviews and six-month 'check ins'. Team members felt comfortable about discussing any issues with the pharmacy manager or the pharmacist.

Targets were set for the New Medicine Service and the Pharmacy First service. The pharmacy manager said that the pharmacy usually met its targets, and the team did not feel under pressure. She said that

the services were provided for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines. There was a separate counter to the side of the dispensary. People could use this if they wanted a bit more privacy when collecting their medicines.

The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. There were two chairs in the shop area. Staff toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And it ensures that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power-assisted door. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacy manager said that the pharmacy checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Pharmacist's information forms were routinely used to ensure important information was available throughout the dispensing and checking processes. Prescriptions for Schedule 3 and 4 CDs were highlighted and the date the medicines were not to be handed out after was added to the label. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacy manager said team members checked CDs and fridge items with people when handing them out. The pharmacy manager said that the pharmacy supplied valproate medicines to a few people. But it did not currently supply these medicines to people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy manager said that people would be referred to their GP if they needed to be on the PPP and weren't on one. And the pharmacy dispensed this medicine in whole original packs.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy manager explained the action the pharmacy took in response to any alerts or recalls it received from its head office. Any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items with a short expiry date were clearly marked. There were no date-expired items found in with dispensing stock when spot checked and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The fridge was suitable for storing medicines and it was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were

recorded. Records indicated that the temperatures were consistently within the recommended range.

Part-dispensed prescriptions were checked frequently. ‘Owings’ notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy manager said that uncollected prescriptions were checked weekly, and people were sent text message reminders. Items remaining uncollected after five weeks were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacy manager said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

Deliveries were made by a delivery driver. The pharmacy booked delivery requests online and the deliveries could be tracked by the pharmacy. The delivery driver obtained people’s signatures for deliveries where possible, and these were recorded in a way so that another person’s information was protected. The pharmacy manager said that the driver would let the pharmacy know if they were unable to deliver a medicine and it would be return to the pharmacy is possible. If the pharmacy was closed, the items were stored appropriately at the ‘hub’ and return to the pharmacy the following day to rearrange delivery. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available in the pharmacy and online. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. The otoscope had been in use for less than one month and it was clean and in good working order.

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.