General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 30-34 Wilmot Square, Pentagon Centre, CHATHAM, Kent, ME4 4BB

Pharmacy reference: 1032681

Type of pharmacy: Community

Date of inspection: 22/08/2024

Pharmacy context

The pharmacy is in a shopping centre in Chatham town centre. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, blood pressure checks, and it uses patient group directions for its contraception service, COVID vaccination and flu vaccination services. The pharmacy 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 supplies medicines to a large number of care homes. The pharmacy also provides substance misuse medications to some 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 future risks. And learning is shared with other pharmacies in the group.
2. Staff	Standards met	2.2	Good practice	Team members are given time set aside to undertake regular and structured training. 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	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 its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce future risks. It protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps its records up to date and accurate.

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. Team members' roles and responsibilities were specified in the SOPs. The pharmacy adviser said that the pharmacy would not open if the pharmacist had not turned up in the morning. She knew that she should not hand out any dispensed items or sell any pharmacy-only medicines if the pharmacist was not in the dispensary.

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 them. 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 highlighted shelf edges where medicines that looked alike or sounded alike were kept. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The store manager said that she was not aware of any recent dispensing errors. She explained that these were recorded electronically, and the pharmacy's head office reviewed them.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. And tubs were used to minimise the risk of medicines being transferred to a different prescription. A quad stamp was printed on prescriptions and dispensing tokens. Team members initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). The accuracy checking technician (ACT) knew which prescriptions she could check. Pharmacist's information forms (PIF) were routinely used to ensure important information was available throughout the dispensing and checking processes.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was displayed, and the RP record was completed correctly. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The CD running balances were checked at regular intervals and any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist routinely asked another team member to check the volume of liquid CDs when dispensing them. The private

prescription records were largely completed correctly, but the correct prescriber details were not routinely recorded. The importance of maintaining complete records about private prescriptions was discussed with the team.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. 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. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Complaints were recorded electronically, and any action taken as a result was recorded and fed back to the head office. The store manager said that there had not been any recent complaints. She explained that complaints were included on patient safety review, and these were discussed with team. The pharmacy gave people cards with details about how they could provide feedback about the pharmacy. The store manager regularly reviewed the feedback page online and shared this with the team. The pharmacy had recently received some positive feedback from people about its blood pressure service.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. A pharmacy adviser described potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough 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 were two pharmacists, one ACT and six trained pharmacy advisers (who had completed accredited dispenser courses) working during the inspection. And the store manager was a trained pharmacy adviser and could provide cover if needed. The store manager explained that holidays were staggered to ensure that there were enough staff to provide cover. There were contingency arrangements for pharmacist cover if needed. 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 pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. One of the pharmacy advisers, when asked, knew about the restrictions on sales of medicines containing pseudoephedrine. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

The pharmacists were aware of the continuing professional development requirement for revalidation. One explained that she had recently undertaken training for the contraception service and the Pharmacy First service. And she was in the process of completing the online flu training. Team members explained how they read updated SOPs and had to pass an online assessment to show that they had understood them. A pharmacy adviser said that team members were provided with additional support with their learning if needed. Team members were allocated protected time during work to complete training. The store manager said that she monitored staff training to ensure that it was undertaken within the required timeframe.

Team members explained that they had a morning huddle to discuss any complaints, issues and allocate tasks. Information such as stock availability, IT issues and inter-store transfers were communicated via the area group chat. The store manager attended a weekly conference call to discuss audits, targets, patient safety, and any other issues. And there was a team meeting held around once every three months. The pharmacy received a monthly newsletter from its head office, and this included pharmacy-related information. The second pharmacist explained that she discussed the contents of the newsletter with team members and signed it to show that this had happened. The pharmacists felt able to make professional decisions. And they had completed declarations of competence and consultation skills for the services offered and had done the associated training.

Team members had yearly performance reviews and they felt comfortable about discussing any issues with the pharmacist or the store manager. Targets were set for the New Medicine Service and the store manager said that the pharmacy usually met the target. The RP said that she felt under a certain

amount of pressure to meet the target, but she provided the service for the benefit of the people using the pharmacy and she would not let it affect her professional judgement.

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 against unauthorised access and there were retractable barriers used to restrict access. Pharmacy-only medicines were kept behind the medicines counter to the side of the dispensary. And shutters were used to cover these medicines when the dispensary was closed. 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. And the pharmacy was bright, clean, and tidy throughout which presented a professional image.

There was seating in the shop area for people to use while waiting for services. The consultation room was accessible to wheelchair users, and it was accessible from the shop area and the dispensary. 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. 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 it manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines and it routinely speaks with people when they collect these medicines. 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. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

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

There were signed in-date patient group directions available for the relevant services offered. And the consultations for the Pharmacy First were recorded electronically. Prescriptions for higher-risk medicines were highlighted, and team members said that they spoke with people when they collected these medicines. Team members routinely checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was recorded on the patient's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted, and this helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. And the prescription expiry date was recorded on the bag label. Dispensed fridge items were kept in clear plastic bags to aid identification. The RP said that team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy dispensed these medicine in their original packaging. The RP said that she would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. Stock was stored in an organised manner in the dispensary and stock due to expire within the next six months were marked. Expiry dates were checked regularly, and this activity was recorded. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. CDs were stored in accordance with legal requirements and 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.

People were sent a text message when their items were ready for collection and then several reminder text messages. Uncollected prescriptions were checked daily using a computer-generated list and items remaining uncollected after around five weeks were returned to dispensing stock where possible. And the prescriptions returned to the NHS electronic system or to the prescriber. Part-dispensed prescriptions were checked frequently and there were only a small number of prescriptions with 'owings' at the pharmacy. '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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The RP said that the pharmacy had carried out assessments for people to show that they needed their medicines in multi-compartment compliance packs. The pharmacy did not order prescriptions on behalf of people who received their medicines in the packs. It 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. The pharmacy supplied the care homes with medicines in original packs alongside medicine administration charts. The care homes were responsible for ordering prescriptions for their residents. Communication between the pharmacy and the care homes was done via email. The pharmacy informed the care homes about any stock issues so that they could arrange prescriptions for alternate medicines if needed. The pharmacy worked around one week in advance so that any issues could be addressed before the person needed their medicine. Team members used a communication book to ensure information was passed on. Emails from the care home were checked regularly throughout the day and this activity was recorded.

Deliveries were made by delivery drivers. Requests for deliveries were made using the pharmacy's computer system. 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. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. 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

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. Gloves were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. The blood pressure monitor had been in use for around two months. The otoscope was cleaned regularly, and disposable tips were used. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.