General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 Hempstead Valley, Shopping Centre, Hempstead, GILLINGHAM, Kent, ME7 3PB

Pharmacy reference: 1032770

Type of pharmacy: Community

Date of inspection: 04/01/2023

Pharmacy context

The pharmacy is in a shopping centre near Gillingham. It provides a range of services, including the New Medicine Service and the flu vaccination service. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines. It receives most of its prescriptions electronically, and it serves a mixed population.

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	N/A	N/A	N/A
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 adequately identifies and manages the risks associated with its services to help provide them safely. Team members record and review their mistakes so that they can learn and make the pharmacy's services safer. The pharmacy largely protects people's personal information. People using the pharmacy can provide feedback about its services. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and team members had signed to show that they had read, understood and agreed to follow them. 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. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. 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. One of the team said that most of the errors were due to the incorrect quantity of medicine being supplied. But they could not think of any recent errors where the wrong medicine had been supplied to a person.

There was a long queue at the dispensary counter throughout the inspection. Team members were continually having to help 'queue bust' while trying to concentrate on other tasks. Workspace in the dispensary was limited and the dispensing and checking areas were kept clear. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And plastic tubs were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. And a quad stamp was used on dispensing tokens and prescriptions. Team members initialled these stamps next to the tasks they had undertaken (dispensed, clinically checked, accuracy checked and handed out the medicines).

Team members' roles and responsibilities were specified in the SOPs. The healthcare adviser said that the pharmacy would not open if the pharmacist had not turned up in the morning. And she knew which tasks she should not carry out if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The private prescription records were completed correctly. But 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. One of the team said that they would remind other team members about entering the nature of the emergency.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the 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. Bagged items waiting collection could be seen by people in the shop area and some people's personal information could potentially be read. Team members said that this had already been highlighted and they were in the process of addressing the issue.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispensary tills printed feedback information on some receipts and people were encouraged to provide feedback. Any feedback received by the pharmacy's head office would be passed on to the store manager. One of the team said that there had not been any recent complaints.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had completed some safeguarding training provided by the pharmacy's head office. The healthcare adviser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. One of the team said that there had not been any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of 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. This means that they can help improve the systems in the pharmacy. The 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, two trained pharmacy advisers (one was undertaking the NVQ Level 3 training), one trainee pharmacy adviser (trainee assistant store manager) and one trained healthcare adviser working during the inspection. Most team members had completed an accredited course for their role and the trainee pharmacy adviser was due to start her training. Team members wore smart uniforms with name badges displaying their role. They worked well together throughout the inspection and communicated effectively to ensure that tasks were prioritised. And although the pharmacy was busy, the workload was generally up to date. One of the team said that the pharmacy was short staffed on the day of the inspection due to unplanned sickness.

The healthcare adviser appeared confident when speaking with people. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And she explained when she would refer to the pharmacist when selling medicines which could be abused or may require additional care. She asked people questions to make sure that over-the-counter medicines were suitable for them to take.

Team members had access to online training modules provided by the pharmacy's head office. They had to completed monthly training modules and read updated SOPs. One of the team explained that they were given protected training time each month to complete the necessary training. But they could also access the training online or on an application on their phone. They said that the pharmacy store manager monitored training to ensure that it was completed within the required timeframe.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. And they felt able to take professional decisions. One of the pharmacists said that they were in the process of learning about a rare skin condition due to the pharmacy recently dispensing prescriptions for it. Targets were set for the New Medicine Service. One of the team said that the pharmacy usually met the target. And team members would not let targets affect their professional judgement.

Team members felt comfortable about discussing any issues with the store manager or pharmacist. There were regular team meetings to discuss any issues. And during the meeting the team discussed the monthly patient safety review of near misses and dispensing mistakes. There were regular informal huddles to discuss any issues and allocate tasks to ensure the workload was managed.

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. Air conditioning was available, and the room temperature was suitable for storing medicines. Pharmacy-only medicines were kept behind the counter. And there was a clear view of the medicines counter from the dispensary and the pharmacist could intervene when needed.

There were several chairs in the shop area for people to use while waiting. These were positioned around the front area of the dispensary counter along where people queued. The pharmacy's 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.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls which helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance and the doors remained open while the pharmacy was open. 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 if needed.

Pharmacist's information forms (PIF) were routinely used to ensure important information was available throughout the dispensing and checking processes. Prescriptions for higher-risk medicines were highlighted using coloured cards and prompt questions were printed on the reverse to assist staff when handing these items out. The pharmacist said that she 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 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. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. 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 pharmacist said that she would refer people to their GP if they were not on a PPP and needed to be on one. The pharmacy had the additional patient information booklets, but team members could not find the extra warning cards and warning stickers for use with split packs. One of the team said that they would order more from the medicines manufacturer if needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next few months were marked. And there were no date-expired items found in with dispensing stock. Short-dated stock forms were used to record items with a short expiry so that these could easily be identified and removed before they had expired. 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 segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

Part-dispensed prescriptions were checked frequently and 'owings' notes were provided when prescriptions could not be dispensed in full. 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. Uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their

items after four weeks. Items remaining uncollected after around five weeks were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. Deliveries were made by delivery drivers working from a central hub and delivery requests were made online using the pharmacy's online system.

People had assessments carried out to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the pharmacy contacted some people to see if they needed them when their packs were due. And other people usually contacted the pharmacy. 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. Team members wore gloves when handling medicines that were placed in these packs.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office and 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.

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 some only used to measure marked for certain medicines. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This 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 phone in the dispensary was portable so it could be taken to a more private area where needed. The blood pressure monitor was 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.