General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7-13 High Street, & 6-8 King Street, RAMSGATE, Kent, CT11 9AB

Pharmacy reference: 1032890

Type of pharmacy: Community

Date of inspection: 03/08/2022

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service, needle exchange, flu vaccinations (seasonal) and emergency hormonal contraception. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

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	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 is good at providing ongoing training for its team members. And they regularly discuss any mistakes that happen.
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 records and regularly reviews any dispensing mistakes to help it improve its services and reduce risk. It identifies and manages the risks associated with its services to help provide them safely. The pharmacy protects people's personal information. And people can feedback about its services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy identified and managed the risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood and agreed to follow the SOPs. And they had to take quizzes to confirm their understanding. 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. Team members identified and rectified their own mistakes. 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. The store manager said that there was a group chat for area managers and any important information was shared ahead of the weekly meetings. As a result, from a patient safety review, higher-risk medicines were now kept separated from other medicines to help minimise the chance of the wrong item being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. And the pharmacy's head office would be informed. The store manager said that there had not been any recent dispensing errors.

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

The customer adviser said that the pharmacy would not open if the pharmacist had not turned up in the morning. She explained that the dispensary staff had the same lunch break and the dispensary would be closed at lunch time. And during this time no pharmacy-only medicines could be sold and no bagged items would be handed out. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. 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 recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. And this could make it harder for the pharmacy to find these details if there was a future query. There were two responsible pharmacist (RP) notices

displayed at the start of the inspection. The display cabinet where one of the notices was displayed was locked and team members could not find the key. The notice was covered so that the details could not be seen which meant that only the right RP notice was on display throughout the remainder of the inspection. The RP record was largely completed correctly. There were several blank lines in the record. The store manager said that the pharmacy would have been closed on these days, and she said that this would be made clear in future.

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. People's personal information on 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 pharmacy gave people information about how to complete the pharmacy's online survey with a chance to win an electronic tablet. The information about how to complete the survey was either attached to the person's bagged items or printed on randomly selected till receipts. The complaints procedure was available for team members to follow if needed and details about how people could provide feedback were available on the pharmacy's website.

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

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is good at providing ongoing training for its team members. Their progress is monitored, and they get time set aside at work to complete it. It has enough trained team members to provide its services safely. Team members can raise concerns about with the pharmacy or other issues affecting people's safety. And they regularly discuss adverse incidents to help the pharmacy improve its services. 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 locum pharmacist, two pharmacy technicians and one trained dispenser (store manager) working during the inspection. There was a customer adviser working at the medicines counter. She confirmed that she had completed the healthcare adviser course. She was not currently employed in that role but she was covering the counter. The 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.

The customer adviser appeared confident when speaking with people. She asked questions to establish whether the medicines were suitable for the person before supplying any over-the-counter medicines. She was aware of the restrictions on sales of pseudoephedrine containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

There were informal team meetings each morning to allow team members to discuss any issues and allocate tasks. The team also discussed any near misses or dispensing errors openly. The pharmacy received regular updates from the pharmacy's head office. Team members signed to show that they had read and understood the information.

The pharmacist and pharmacy technicians were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist said that she had recently undertaken some training about an advanced hypertensive service and safeguarding training. Team members undertook ongoing online training provided by the pharmacy's head office. And this was monitored by the store manager. The store manager explained that team members were allocated regular training time so that they could complete the modules while at work. They could also access them at home if they preferred but the store manager said that this was not encouraged. The team also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist felt able to make professional decisions. And she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The store manager said that there had been ongoing informal staff performance reviews since she had started in her role around on year ago. And she explained that she was due to undertake more formal appraisals and reviews for all team members which would be documented. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions.

Targets were set for the New Medicine Service. The store manager said that the pharmacy usually met

its targets. There was a certain amount of pressure for the pharmacy to meet the targets. But the pharmacist would not let the targets affect her professional judgement. And the team carried out the services for the benefit of the people who use 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. And 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. Toilet facilities and the staff room were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

There were two chairs in the shop area and one had arms to aid standing. The chairs were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located 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

The pharmacy managed its services well and provides them safely. It highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. It stores its medicines properly and 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 automatic doors. 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.

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. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted using coloured cards. Prompt questions were printed on the reverse of the cards to assist staff when handing these items out.
'Pharmacist 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 last date the supply could be made was written on the sticker. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. CDs and fridge items were checked with people when handing them out. The pharmacist said that 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. Team members could not locate the additional warning cards, patient information leaflets and warning stickers during the inspection. One of the team said that they would contact the manufacturer to request these.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly and this activity was recorded. Items due to expire before the end of the year were marked. And lists were kept so that the items could easily be identified and removed around one month before they were due to expire. There were no date-expired items found in with dispensing stock.

Uncollected prescriptions were checked daily. The store manager explained that a list was printed each day for items that had remained uncollected for five weeks. And people were then sent a text message reminder and if they did not collect their medicines after a further seven days. Any remaining uncollected items were returned to dispensing stock where possible. And the prescriptions were returned to the NHS electronic system or to the prescriber. 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.

Multi-compartment compliance packs were assembled in a room which was separate to the dispensary area. This helped to minimise distractions. There were several team members who could manage the packs and there was a well-organised system for this. The pharmacy technician said that people had assessments carried out by their GP to show that they needed their medicines in the packs. And prescriptions were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy did not routinely request prescriptions for 'when required' medicines ad people usually contacted their GP if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they 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. This made it easier for people to know how to take their medicines safely. The pharmacy technician said that she wore gloves when handling medicines that were placed in these packs.

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.

Deliveries were made by delivery drivers. The pharmacy obtained people's signatures for deliveries where possible and these were recorded on a hand-held electronic device and this meant that other people's personal information was protected. This made it easier for the pharmacy to show that the medicines were delivered to the right person. When the person was not at home, the delivery was usually returned to the pharmacy before the end of the working day. If the pharmacy was closed, the medicines would be taken to the pharmacy's hub to be stored. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. Any action taken was recorded and kept for future reference, and the pharmacy's head office was informed. 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 separate liquid measures were used to measure marked for use with certain liquids. 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.

Fridge temperatures were checked daily and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. Fridge temperature anomalies were investigated and a record of any action taken was kept for future reference.

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.