General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 122 High Street, SITTINGBOURNE, Kent, ME10 4PH

Pharmacy reference: 1032963

Type of pharmacy: Community

Date of inspection: 22/08/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre surrounded by residential premises. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, flu vaccinations, emergency hormonal contraception and anti-malarials. And it receives around 95% of its prescriptions electronically. It supplies medication in multi-compartment compliance packs to large number of people who live in their own homes to help them manage their medicines. It supplies medicines to a large number of care homes. And it provides substance misuse medications to a few 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	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.
		2.4	Good practice	The pharmacy has a good culture of learning. It promotes learning, continuous improvement and the personal development of its team members. Team members are open about any mistakes that happen. And they regularly discuss them to make the pharmacy's services safer.
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

Overall, 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 any future risk. It regularly seeks feedback from people who use the pharmacy. It largely protects people's personal information well. And it generally keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people and take appropriate action when needed.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. The team members had signed the SOPs to show that they had read and understood them.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Medicines in similar packaging or with similar names were separated where possible. The accuracy checking technician (ACT) said that team members double checked their own dispensing before it was passed to her to be checked. Pharmacist's information forms (PIF) were routinely used to ensure important information was available throughout the dispensing and checking processes. The age of a child was recorded on the PIF so that this was highlighted. The accuracy checking tool was displayed at each dispensing station for team members to refer to. This reminded team members what needed to be checked during the dispensing and checking processes. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong bag of medicines had been supplied to a person. The person returned the medicines to the pharmacy and was provided with the correct medicines. The name on the prescription sounded like the name on the bag label but it was not the same. To help prevent a recurrence the pharmacist who handed it out had re-read the handing out of medicines SOP and watched a video explaining the correct procedure. And team members were reminded to check the address provided by the person against the bag label and the prescription before handing the medicines over.

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. A quad stamp was printed on prescriptions and dispensing tokens; staff initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out).

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would remain closed if the responsible pharmacist had not turned up. She knew that she should not carry out any dispensing tasks until the pharmacist had arrived. She explained that she would not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And the pharmacy had signed in-date patient group directions for the services offered. The private prescription records were mostly completed correctly, but the correct prescriber details and the date on the prescription were not always 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. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running balances were checked regularly. Liquid controlled drug 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 address of the supplier was not recorded in the registers and there were alterations made to the registers. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query. The responsible pharmacist (RP) log was largely completed correctly. The pharmacist had completed the log before finishing her shift and had entered the time she was due to return from her break before she had returned. The correct RP notice was clearly displayed. The pharmacist said that she would remind team members to ensure that the private prescription record, the emergency supply record, the CD registers and the RP log were completed correctly in future.

Patient confidentiality was largely protected. 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 in the dispensary. Smart cards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on dispensed items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training. The screen on the computer in the consultation room was not kept secured when not in use and people's personal information was accessible. This was discussed with the pharmacist during the inspection. There were some adrenaline pens kept in the room, and a trainer pen was kept with them. This may cause confusion if the adrenaline was needed to be used in an emergency. The pharmacist removed these items during the inspection and said that they would be kept separated.

The pharmacy carried out yearly patient satisfaction surveys; results from the recent survey were displayed in the shop area and were available on the NHS website. The complaints procedure was available for team members to follow if needed. The store manager received feedback from the online survey. People who responded to the survey were entered into a monthly draw with the chance to win an iPad mini. The pharmacist said that the pharmacy had received a recent complaint when a person had requested to purchase an over-the-counter medicine. The pharmacist said that the answers the person gave meant that the medicine may not have been suitable for them to take so the supply was not made.

The pharmacist and accuracy checking technician (ACT) had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy technician said that there had been a recent safeguarding concern at the pharmacy and an ambulance had been called. 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. 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 was one pharmacist and two trained dispensers working in the dispensary on the day of the inspection. The store manager was a trained dispenser and helped out when needed. There was one ACT and three trained dispensers working upstairs assembling the multi-compartment compliance packs. 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 dispenser said that there had been an occasion recently when team members were struggling to have their breaks. She said that there was a member of the team on planned leave and one on unplanned sick leave. The store manager was made aware of the concerns during the inspection.

The dispensers appeared confident when speaking with people. A dispenser who the inspector spoke with was aware of the restrictions on sales of pseudoephedrine containing products and knew the reason for this. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members had completed accredited pharmacy courses for their role. They completed regular training, including: e-Learning modules, manual handling, health and safety, fire, slips and trips, age restrictions and CPPE children's oral health. Training was checked by the store manager and team members had 30 minutes each week of protected training time to complete the modules. The pharmacist and ACT were aware of the Continuing Professional Development requirement for the professional revalidation process. Team members were in the process of undertaking training on gabapentin and pregabalin medicines as part of the 'look alike, sound alike' drugs. The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacy team had an informal huddle each morning to discuss their plan for the day and to allocate tasks. They had a patient safety meeting once a month and discussed near misses and dispensing incidents. Team members had performance reviews and appraisals every three months with the store manager. They said that they felt comfortable about discussing any issues or concerns with the store manager or pharmacist. One of team said that they had raised concerns about staffing levels so to help address this the store manager helped with dispensing when possible.

Targets were set for Medicines use Reviews (MUR) and the New Medicine Service. The pharmacist said that the pharmacy should meet the MUR target this year. She confirmed that she did not feel under

pressure to achieve the targets and provided the services for the benefit of people who used the pharmacy. And she would not let targets affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But the pharmacy could do more to ensure that it addresses routine maintenance issues promptly.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. The store manager said that people often stood at the medicines counter waiting to be served when the pharmacist was on their lunch break. A notice was displayed at the dispensary counter explaining that the pharmacist was on a break, but this could not be read from the medicines counter. The lights in the dispensary were turned off during this time, but it was not clear that the medicines counter was also closed. She said that people often expressed their frustration at waiting to be served and then being told that they could not purchase some of the medicines. 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; the room temperature in the dispensary was suitable for storing medicines. The tap in the consultation room could not be turned off fully and the water ran constantly. One of the main lights above the dispensary was flickering when it was turned on. The dispenser said that this happened for a few minutes after it was turned on and it had been fixed several times. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened, but it was not the door was not lockable. Low-level conversations in the consultation room could not be heard from the shop area.

There were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. A hatch was available from the shop area to the dispensary. This meant that some people would have added privacy when talking to the pharmacist if needed.

The multi-compartment compliance packs were assembled in a room upstairs. The room felt humid and had a musty smell. The weather outside was warm. There was no natural light into the room and no fresh air coming into the room. But the room did have air-conditioning. Some of the lights were dull and others were bright. The ACT said that there had been plans to install new lighting around one year ago, but this had not happened. There was another large room upstairs which had natural light and windows that could be opened. The room was currently used as a tea room and was next to the kitchen.

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

Overall, the pharmacy manages its services well and provides them safely. It 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. Services and opening times were clearly advertised and a variety of health information leaflets were available. The induction hearing loop appeared to be in good working order. The store manager and pharmacist used personal protective equipment when disposing of returned medicines. The store manager knew which medicines required denaturing before disposal.

A record of blood test results was kept for people taking higher-risk medicines including methotrexate and warfarin and these were recorded on the PIF and 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 higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The ACT said that care homes provided the pharmacy with blood test results for their residents who took higher-risk medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these being handed out when the prescription was no longer valid. Dispensed fridge items and CDs were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items 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. The ACT said that all people in the at-risk group were provided with warning cards and patient information leaflets.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was marked. There were no date-expired items found in with dispensing stock. And medicines were kept in appropriately labelled containers.

Part-dispensed prescriptions were checked were checked twice a day. '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. Uncollected prescriptions were checked weekly using the colour coded prescriptions retrieval calendar. The store manager said that people were sent a text message reminder if they had not collected their items after four weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

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 ACT said that the

pharmacy contacted people each month to see if they needed them. 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. A communication book was used to ensure that any changes to people's medicines were passed on to all team members. 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 ACT said that the care homes were responsible for ordering prescription for their residents. The care home service appeared to be well organised and packs were assembled before people needed their medicines.

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; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy 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.

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

The pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. The store manager said that the pharmacy was due to have the equipment installed before the end of the year.

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. Separate liquid measures were marked for controlled drug use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around two months. The weighing scales did not appear to be in good working order. The store manager said that she would remove them from the consultation room. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were largely within the recommended range. Any anomalies were investigated and a record was kept for when the temperatures were re-checked. The fridge was suitable for storing medicines and was not overstocked.

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.