General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Wymondham Medical Centre, Postmill Close, Wymondham, Norfolk, NR18 0NL

Pharmacy reference: 1035391

Type of pharmacy: Community

Date of inspection: 27/10/2023

Pharmacy context

This community pharmacy is located next to a medical centre in the town of Wymondham. It provides a variety of services including dispensing NHS prescriptions , the New Medicine Service (NMS), supervised consumption of medicines and season flu vaccinations through a patient group direction (PGD). It also provides medicines in multi-compartment compliance packs for people who have difficulty remembering to take their medicines.

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	N/A	N/A	N/A
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 manages the risks associated with its services well. And its team members record and regularly review any dispensing mistakes. The pharmacy keeps the records its needs to by law. And people can provide feedback about its services. The pharmacy has appropriate insurance arrangements in place. And its team knows how to protect vulnerable people.

Inspector's evidence

The correct responsible pharmacist (RP) notice was on display in the pharmacy. There was a range of standard operating procedures (SOPs) that had been issued by the pharmacy's head office. These were available electronically and had been read by all staff members. The store manager had access to team members' profiles to view their progress with reading them. Near misses (dispensing mistakes which were spotted before a medicine leaves the pharmacy) were recorded electronically. Dispensing errors (mistakes which had reached a person) were also recorded electronically and in more detail. One of the technicians working at the pharmacy was a patient safety champion who was responsible for reviewing near misses and errors for any trends. The team also had a monthly meeting to discuss any near misses and dispensing errors.

Complaints and feedback were usually submitted online. A team member said that any complaints or feedback about the pharmacy could also be given in person or via a phone call and would be actioned in the same way. Complaints were usually resolved in store but could be escalated to head office if necessary.

Confidential waste was disposed of in a dedicated confidential waste bin. When full, the waste was bagged up and taken away by an external company for safe disposal. No confidential waste was found in the general waste bin. The team said that they sought the appropriate details from people collecting medicines or phoning the pharmacy for information. The RP confirmed that he had completed level two safeguarding training with the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy manager confirmed that all other team members had completed level one safeguarding training. The team members knew what to do if a vulnerable person presented in the pharmacy and gave examples of previous safeguarding issues they had dealt with. The pharmacy had contact details of local safeguarding leads.

The pharmacy had current indemnity insurance. Balance checks were carried out regularly for controlled drugs (CDs), and records seen in the CD register were made in accordance with the law. A random check of a CD showed that the quantity in stock matched the running balance in the register. Records seen about private prescriptions dispensed were largely complete, although some were missing the address of the prescriber. The RP said this would be included going forward. Records about unlicensed medicines supplied were complete and included all required details including the name of whom the medicine was for and the date of dispensing. The RP explained that the pharmacy received very few requests for emergency supplies as it was next to a medical centre. But records seen for supplies were complete and listed the nature of the emergency . The RP record was also complete with all entries seen having a start and finish time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. And team members do the right training for their roles. Team members do some ongoing training to keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

On the day of the inspection, there was the RP and a second pharmacist, a pharmacy manager and four other team members. The pharmacy was busy with a regular queue of people, but team members worked well together to provide an efficient service. And they were up to date with dispensing. Team members were observed asking the appropriate questions when supplying pharmacy only (P) medicines. The pharmacy was due to have a new team member start the following week. All team members had completed the appropriate training for their roles with an accredited training provider. Team members were provided with ongoing training in the form of e-learning from head office, and a team member confirmed that they had a formal appraisal every six months. Team members knew what they could and could not do in the absence of an RP. They had no concerns about raising any issues and would usually go to the RP or head office if necessary. The pharmacy team was not set any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and provides a safe and appropriate environment for people to access its services. People can have a conversation with a team member in a private area. And the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The front facia of the pharmacy was in a good state of repair. The shop floor was clean and professionally presented. It had enough space and had chairs for people who wished to wait for their prescription. P medicines were stored securely behind the counter. The dispensary area was clean and tidy and had plenty of floor and desktop space for the team to work in. It had a small sink for the preparation of liquid medicines which was kept clean. The temperature and lighting of the pharmacy were adequate. And the pharmacy had air conditioning allowing for the temperature to be adjusted when necessary. There was a staff toilet with access to hot and cold running water and handwash, and a breakroom for team members.

The pharmacy had a consultation room for people who wished to have a conversation in private. It allowed for a conversation at a normal level of volume to be had without being heard from the outside. The room was a good size, and it was kept clean and was locked when not in use. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And it gets its medicines from reputable sources and stores them appropriately. The pharmacy can cater to people with different needs. And it responds to safety alerts and recalls of medicines and medical devices appropriately. So, this helps people be sure that they are getting medicines that are fit for purpose.

Inspector's evidence

The pharmacy had step-free access via a manual door. It was able to cater for people with different needs, for example by printing large-print labels for people with sight issues. It also had a hearing loop. There was just enough space for people with wheelchairs and pushchairs to access the dispensary counter. The dispensary had separate areas for dispensing and checking medicines, and multi-compartment compliance packs were prepared in a designated area at the back of the pharmacy. Baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines seen contained the initials of the dispenser and checker and this provided an audit trail.

The pharmacy provided a delivery service for people who had difficulty collecting their medicines from the pharmacy. The delivery driver used a secure electronic device to keep a record of deliveries, the pharmacy also kept a paper record of deliveries. The pharmacy usually phoned each person the day before their delivery was due to confirm the delivery. If there was a failed delivery, the medicines would be returned to the pharmacy and a note put through the door with information about arranging a redelivery. If the pharmacy had not heard from a person for a couple of days after a failed delivery, they would telephone the person.

The pharmacy used cards and stickers to highlight prescriptions that contained a high-risk medicine, a CD or an item requiring refrigeration. The RP confirmed that he or the second pharmacist always handed out high-risk medicines and that people received the appropriate counselling for their medicines. The patient medication record (PMR) highlighted CD prescriptions that were soon to expire to help reduce the risk of a prescription that was no longer valid being given out.

Prepared multi-compartment compliance packs seen contained all the required dosage and safety information as well as a description of the tablets. This included a description of the colour, shape and any markings on the medicines to help people identify their medicines. Team members confirmed that patient information leaflets (PILs) were always included with each supply of the packs. A team member said that they would contact the surgery regarding any queries they had with prescriptions such as unexpected changes to people’s treatment.

The pharmacy obtained medicines from licensed wholesalers and invoices were seen confirming this. CDs requiring safe custody were stored securely and medicines requiring refrigeration were stored appropriately. Fridge temperatures were checked and recorded daily, and records seen were all in the required range. The maximum temperature of one of the fridges was slightly over the appropriate range during the inspection. The team said this was due to date checking which had been done earlier. The fridge thermometer was reset and then showed a temperature within the appropriate range. Expiry date checks were done weekly on a rota basis with a different section being checked each time. A paper

rota showed that recent checks had been completed, and a random check of medicines on the shelves revealed no expired medicines. Safety alerts and recalls were received by email. The pharmacy had a team member who was responsible for actioning the alerts, which were printed and actioned as appropriate before being archived.

Team members were aware of the risks of sodium valproate, and the RP knew what to do if a person in the at-risk category presented at the pharmacy. The RP confirmed the pharmacy had no one in the at-risk category currently taking sodium valproate. Team members were shown where to apply a dispensing label to a box of sodium valproate as to not cover any important safety information. The pharmacy had a patient group direction (PGD) for the administration of seasonal flu vaccinations. The PGD was signed and in date. The pharmacy also had access to an anaphylaxis kit for anyone who had a reaction to the vaccination. All the items in the kit were in date and fit for use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment it needs to provide safe and effective services. And it uses its equipment to protect people's privacy.

Inspector's evidence

The pharmacy computers had access to the internet allowing team members to access any online resources they needed. Computers were password protected and faced away from public view to protect people's privacy. Team members were observed using their own NHS smartcards. The pharmacy had cordless phones so conversations could be had in private. The team confirmed that electrical equipment was due to be safety tested next month. The pharmacy had a blood pressure monitor in the consultation room. The team was aware that it required recalibration within the next six months. The pharmacy had the appropriate calibrated glass measures for measuring liquid medicines. It also had tablet triangles for counting medicines and a separate one for counting cytotoxic medicines such as methotrexate.

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.