

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 35 Gold Street, KETTERING,  
Northamptonshire, NN16 8JL

**Pharmacy reference:** 1035416

**Type of pharmacy:** Community

**Date of inspection:** 09/01/2020

## Pharmacy context

This community pharmacy is situated in a shopping centre in the middle of the town. Most of the activity is dispensing NHS prescriptions and giving advice about medicines over the counter. Other services that the pharmacy provides include substance misuse services, travel vaccinations and seasonal flu vaccinations against patient group directions, prescription deliveries to people's homes, Medicines Use Reviews (MUR) and New Medicine Service (NMS) checks.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks associated with the provision of its services. Its team members have defined roles and accountabilities. The pharmacy has processes for learning from its mistakes. The pharmacy adequately manages people's personal information. It knows how to protect vulnerable people. The pharmacy doesn't always fully follow its own clinical governance procedures.

### Inspector's evidence

The responsible pharmacist (RP) notice showing the pharmacist in charge of the pharmacy was clearly displayed. As part of the dispensing of a prescription a pharmacist's information form, referred to as a PIF, was completed. Staff explained that the PIF was used to highlight key risks to the pharmacist such as new medicines, change of dose or strength. Most prescriptions checked had a PIF attached. A member of the team explained the principle behind the look-alike, sound-alike (LASA) protocol. There were laminates attached to the computers listing the medicines most likely to be picked by mistake. She explained that as part of the process the name of these medicines should be written on the PIF. When checked PIFs did not have this information recorded. The pharmacy had a set of up-to-date standard operating procedures (SOPs). The pharmacist and one of the dispensers had not signed the SOP checked.

The pharmacy also had a number of prompt cards which should be placed with dispensed prescriptions. Cards said if there was a controlled drug (CD) or fridge line or to refer a person collecting a prescription to the pharmacist for counselling. In addition, there were cards for higher-risk medicines such as lithium, methotrexate or warfarin, with questions the member of staff handing out the medicine should ask the person collecting the prescription.

The counter assistant knew how to sell a medicine safely. She could give suitable advice. A dispenser knew that most prescriptions were valid for six months and that prescriptions for CDs were valid for 28-days after the date on the prescription. She could recall most, but not all, of the CDs that were not kept in the CD cupboard. The pharmacy had a system for managing all prescriptions waiting collection. After the prescription had been checked the person was texted to tell them their medicine was ready. All people who had a dispensed prescription at the pharmacy were sent a text on a Tuesday to remind them to collect it.

The pharmacy kept records of near misses, errors and incidents. Near misses were discussed with the member of staff responsible at the time they were found. A record was then made in the near miss log. The near miss log for December 2019 didn't have any comments recorded in the comments section. There was only a small number of near misses recorded. The pharmacist explained that with the new computer system medicines had to be scanned before a dispensing label was generated. This had reduced the number of picking errors made. At the end of the month a patient safety review was carried out by the pharmacy technician. The December review was on display in the pharmacy. The review highlighted the need to re-do LASA training with the whole team. This had also been highlighted on some previous monthly patient safety reviews.

The pharmacy provided a range of vaccinations through patient group directions (PGDs) including flu and travel vaccinations. The PGDs seen were in date and training records were available. There was no record to show that the pharmacist had signed the latest NHS PGD for flu vaccinations. The latest

patient satisfaction survey was on the NHS UK website. 92% of people who had completed the survey had rated the pharmacy as excellent or very good. There was a complaints procedure in place. There were contact details for Boots customer care service on the back of till receipts.

Public liability and professional indemnity insurance were in place. The pharmacy had records to support the safe and effective delivery of pharmacy services. The CD register was completed correctly; CD running balances were mainly checked regularly. A random check of the recorded running balance of a CD reconciled with the actual stock. Out-of-date and patient-returned CDs were clearly marked and separated. There was a record of patient returns which included Schedule 3 CDs. Private prescriptions were recorded electronically. The prescription checked had a different prescriber from the electronic record. This could cause confusion if there was need to check the prescription in the future.

Computer terminals were positioned so that they couldn't be seen by people in the retail area. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was bagged and sent away for secure destruction. Confidential information was mainly stored securely. Some patient information was not locked away in the filing cabinet in the consultation room; the room was locked to prevent customer access.

There was an information governance protocol in place. The pharmacy team was aware of the safeguarding procedure; the pharmacist had completed the corresponding CPPE training. Local contact details were available if the pharmacy needed to raise any safeguarding concerns.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. Team members work well together and adequately manage the workload. They can raise concerns if needed. The team members receive support in keeping their skills and knowledge up to date.

### Inspector's evidence

The pharmacy displayed who the RP in charge of the pharmacy was. The RP record showed who the RP in charge of the pharmacy had been. During the inspection the pharmacy had a pharmacist; three qualified dispensers and a counter assistant.

The pharmacy team worked well together during the inspection. Staff said that they had an annual appraisal and that they found the pharmacy manager easy to speak to. They felt able to raise concerns if necessary.

There was a range of training for all staff on the e-Learning site; staff were up to date with this training. Staff said that they read the monthly newsletter from the superintendent and that the pharmacist gave them informal training. The pharmacist said that there wasn't time for the team to study the monthly 30-minute tutors. Although targets for services were set the pharmacist said they didn't compromise customer service or his professional integrity.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy keeps its premises safe, secure and appropriately maintained. The pharmacy protects personal information.

### Inspector's evidence

The pharmacy was maintained to a suitable standard. The dispensary was a reasonable size for the services provided. The dispensary was clean and tidy and there was a sink with hot and cold water. The pharmacy had air conditioning to provide an appropriate temperature for the storage of medicines; lighting was sufficient. There were separate areas for the assembly and checking of medicines.

A good-size sound-proof consultation room was available and used to ensure that people could have confidential conversations with pharmacy staff were appropriate and on request. Computer screens were set back from and faced away from the counter. Access to the PMR was password protected. Unauthorised access to the pharmacy was prevented during working hours and when closed.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides its services safely. The pharmacist is helpful and supportive to people who use the pharmacy. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it takes the right actions if any medicines or devices are not safe to use to protect people's health and wellbeing.

### Inspector's evidence

The pharmacy was situated in the shopping centre in the middle of town. The pharmacy had automatic double doors to provide easy access for wheelchairs and those with mobility problems. Opening times were displayed; staff had uniforms so that they could be clearly identified but most didn't have name badges. The pharmacist had an understanding of signposting and knew how to direct people to local health services.

Work was prioritised based on whether the prescription was for a person who was waiting or coming back. The pharmacy used baskets during the dispensing process to reduce the risk of error. There were separate areas for the assembling and checking of medicines. An audit trail was created using 'dispensed by' and 'checked by' boxes and the use of the quad box on the prescription. The final check was carried out by the RP.

During the inspection the pharmacist mainly worked on the front counter and was easily available to speak to people visiting the pharmacy. The pharmacist said that he gave advice to people using the pharmacy on a range of matters including dose changes, antibiotics and new medicines. He and the team spoke to people taking higher-risk medicines such as methotrexate, lithium and warfarin. They aimed to record people's INR levels. The pharmacist was aware of the advice about pregnancy prevention that should be given to people in the at-risk group taking sodium valproate. He had some but not all of the cards and leaflets that should be given out.

The pharmacy had a chart on display in the pharmacy to make sure that people who received their medicine in a compliance pack got them in time. Each person had an individual record which listed their medicines and when they should be taken. Records seen had medicines crossed through and doses or strengths changed; this made them more difficult to read and increased the chance of an error. Prescriptions were checked with the record and any differences were checked with the surgery before a supply was made. The medicine administration chart (MAR) charts recorded the shape and colour of the medicine to allow easy identification. Patient information leaflets (PILs) were sent with a new medicine but were not routinely sent. This might mean that some people did not have all the information they needed to take a medicine safely. The pharmacy had recently assessed each person to make sure a compliance pack was suitable for them. At the time of inspection, the pharmacy didn't have the capacity to take on additional compliance packs so were signposting people to other pharmacies.

Medicines were stored on shelves tidily and in original containers. Date checking was carried out on a three-month rotation; stickers were used to highlight short-dated medicines. Out-of-date medicines were put in yellow waste bins. Most but not all bottles had the date of opening recorded. The pharmacy delivered medicines to people. The person who received the medicine signed for the medicine to create

an audit trail. Only recognised wholesalers were used for the supply of medicines. The pharmacy team was aware of the procedure for drug alerts. A record was created and signed to provide a complete audit trail. The pharmacist was aware of the Falsified Medicines Directive.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has access to the appropriate equipment and facilities to provide the services that it offers. It adequately maintains its equipment and facilities.

### Inspector's evidence

The pharmacy used crown marked measures for measuring liquids; separate measures were used for CDs. The pharmacy also had tablet and capsule counters. The pharmacy had a range of up-to-date reference sources. Electrical appliance testing was next due in May 2020. CDs were stored securely. The pharmacy had three fridges. Records showed that medicines were stored correctly within the range of 2 and 8 degrees Celsius. When checked one of the fridge's had a maximum temperature that was above 8 degrees Celsius. The pharmacist said he would investigate.

### 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.