General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 3 Cambridge Retail Park, Newmarket Road, CAMBRIDGE, Cambridgeshire, CB5 8WR

Pharmacy reference: 1085016

Type of pharmacy: Community

Date of inspection: 29/01/2024

Pharmacy context

This community pharmacy is on a retail park on the outskirts of Cambridge. It is open from 9am to 8pm, Monday to Saturday and 10am to 4pm on Sundays. Its main activity is dispensing NHS prescriptions, some of which it delivers to people's homes. It provides seasonal flu vaccinations and pneumococcal vaccinations. And the pharmacy offers the NHS hypertension case-finding service and Community Pharmacist Consultation Service. It also participates in the 'Our future health' research programme.

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	1.2	Good practice	The pharmacy team proactively looks for opportunities to improve and encourages its team members to learn from mistakes.
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

The pharmacy's team members follow written procedures to provide services safely. They record their mistakes and review them regularly, so they can learn and reduce risks. And they understand what they can and cannot do when there is no pharmacist present. The pharmacy keeps the records it needs to be law. It generally protects people's private information well. And its team members know what to do to protect vulnerable people.

Inspector's evidence

Pharmacy services were supported by standard operating procedures (SOPs) which were reviewed regularly. These were in digital format and team members could access through the company's online portal. The assistant manager explained how she kept track of which members of staff had read SOPs relevant to their role and would follow-up on any that were outstanding. Prescription labels were initialled at the dispensing and checking stages. A quad stamp was also applied to prescription forms and was initialled to show who had completed a clinical check, who was involved in dispensing and accuracy checking, and who handed out the prepared item.

The team members said that the pharmacist pointed out any dispensing mistakes the staff had made, and which were picked up during the final check of prescriptions (known as near misses). These events were generally recorded on paper first and then added to an online recording platform. Dispensing mistakes which reached patients (known as errors) were also recorded and were subject to an in-depth review to understand what had gone wrong and any learning points for the team. Near misses and errors were reviewed as part of a monthly patient safety review process to help identify patterns and trends and establish safer ways of working. An action point in recent patient safety reviews was encouraging greater recording of near misses and there was evidence that this was happening in practice. The team members commented that dispensing mistakes involving picking errors had reduced significantly since the introduction of scanning equipment which checked that the correct item had been selected. Near misses were now largely down to quantity errors. The team had also done a lot of work to improve how medicines were handed out to people to reduce the chances that items stored separately, such as fridge lines, weren't missed. And to make sure medicines were handed out to the right people.

When asked, team members could confidently explain what they could and couldn't do in the absence of a responsible pharmacist (RP). They could describe the types of questions to ask when selling medicines and knew which ingredients needed greater care including codeine and pseudoephedrine. The pharmacy did not sell codeine linctus or Phenergan elixir over the counter. There was a company complaints procedure which the assistant manager was able to describe. Information about how people could provide feedback about the service they had received was included on every till receipt.

There were appropriate insurance arrangements in place for the services provided. The RP notice correctly showed who the pharmacist in charge was and it was displayed clearly. The RP record and records about controlled drugs (CDs) were complete and running balances were checked regularly. Private prescription records were made electronically in a timely way. Records for the supply of unlicensed medicines contained all the necessary information.

The pharmacy protected sensitive information in several ways. Confidential waste was separated and disposed of securely. There were procedures and training about information governance. Patient medication records were password protected and staff used their own NHS smartcards to access electronic prescriptions; passwords were not shared. Some details on a small number of prescriptions waiting to be collected could be seen from the shop floor. When this was pointed out, the assistant manager said they would address this as soon as possible.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. Staff, including the RP, had completed safeguarding training relevant to their roles. The team was able to describe the types of situations which might need referring to other agencies for support and advice.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team gets the support it needs to improve its services and provide safe services to people. The pharmacy has enough team members who have the right skills and training to provide the pharmacy's services safely. They are well-supported in ongoing learning and development, and they have some set-aside time at work to training. The team uses mistakes as opportunities to learn and improve.

Inspector's evidence

At the time of the inspection a part-time employee pharmacist was providing RP cover. The rest of the team comprised: a pharmacy technician who was also the assistant store manager, two trained dispensers and a trainee dispenser. There were a further two dispensers and a medicine counter assistant not on duty during the inspection. The team members coped well with their workload during the visit and were observed working closely together, referring queries to the pharmacist where needed.

The team members were provided with online training materials from their head office. Some of the training modules were considered mandatory to complete to ensure team members kept their knowledge current. And they got some set-aside time at work to do training. Progress on training was tracked. Team members had reviews with their manager, and these looked at how the member of staff was doing, opportunities to develop their skills, and if they needed any additional support with training. Information was shared amongst the team in a variety of ways including through group chats and team briefing materials.

Team members said they could share suggestions about how to improve the way the pharmacy worked. And the team members asked said they could discuss concerns with the pharmacists, store manager or area manager. There was also a whistle blowing policy, details of which were advertised to the team. The branch had been through some very challenging times due to the increase in workload but were now on a more even keel. The assistant manager was very grateful for the support she and the team had received from the company to help the pharmacy improve.

There was information displayed in the dispensary about monthly safety reviews which highlighted any learning points from these reviews. There were also copies of company newsletters which included safety information and learning from incidents that had happened in other locations. The pharmacist was able to exercise his professional judgement when delivering services and explained various professional development activities he had undertaken to keep his own skills and knowledge current.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are suitable for the services the pharmacy provides. The pharmacy team makes sure the premises are kept clean and well-organised to help make its services safer. And the pharmacy is kept secure.

Inspector's evidence

There was flat access into the pharmacy and automatic doors so the premises could be accessed by people with wheelchairs, prams or other mobility problems. There was seating for people close to the pharmacy counter. Access to the dispensary was restricted and activities carried out in the dispensary were largely out of view of the public, meaning staff were less likely to be disturbed mid-task. Dispensary benches were clear of clutter and various sections of bench and shelving were used for designated purposes, to reduce risks. Pharmacy-only and prescription medicines were kept out of the reach of the public. The pharmacy had introduced an additional storage area for bulkier items and sundries and two medicine fridges were also kept in this area. This extra facility had relieved pressure on space in the dispensary and helped safer ways of working.

A consultation room was located just off the shop floor, and this was used for services and private conversations. The room had access to patient medication records, and it had adequate seating and space for the activities undertaken. The room was not lockable but there was no confidential information left in the room unattended. The glass door could be obscured to provide good privacy and conversations in the room would not be overheard from outside.

All areas of the premises were clean. Staff had access to hygiene facilities including separate hand-washing arrangements. The sink in the dispensary had hot and cold running water. The premises could be secured to prevent unauthorised access. The ambient temperature and lighting during the inspection were suitable for the activities undertaken.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has adjusted the services it offers to make sure it can provide them safely and effectively. And it plans the introduction of new services appropriately. The pharmacy gets its stock from reputable sources and stores it safely. It has good systems in place to make sure the medicines it supplies are fit for purpose. The pharmacy team members know the extra care they need to take when supplying valproate-containing medicines.

Inspector's evidence

The pharmacy's workload had increased significantly due to other local pharmacies closing. To be able to cope with the increase and provide services safely, the pharmacy had reviewed its service provision and had made arrangements for people to receive some services from other pharmacies. This included substance misuse treatments and multi-compartment compliance packs. The pharmacy team members were currently preparing for the launch of the new Pharmacy First service and had been on training courses to be able to provide this service safely; accompanying SOPs had just been received at the branch. The assistant manager explained that the volume of consultations the pharmacy was expected to provide under this service was to be limited in the early days, to manage the impact of the service and maintain other services safely.

A prescription delivery service was offered to assist some people to access their medicines. Prescription deliveries were recorded so that there was evidence to show medicines had reached the right person. Information about the services the pharmacy offered currently were advertised by way of leaflets and posters displayed in the pharmacy. The pharmacy participated in the 'Our Future Health' project which included taking blood samples and giving people advice about their health risks. The team members involved in this service had received dedicated training to provide this safely and the service was monitored by the commissioners.

When asked, a dispenser was able to clearly explain the information that needed to be provided about pregnancy prevention when supplying sodium valproate. And they knew how to attach dispensing labels to the manufacturer's packs so as not to obscure important information. They also knew about the recent changes that meant valproate-containing medicines were to be supplied in their original packs. Alert cards (laminates) were attached to prescriptions for valproate-containing medicines and other higher-risk medicines including CDs so appropriate counselling and advice could be given to people when they collected their medicines. The team members knew that prescriptions for CDs were only valid for 28 days and said that prescriptions for all CDs in schedule 2,3 and 4 would be highlighted. The pharmacist had already marked a prescription for a schedule 2 CD which was no longer valid, to prevent its supply. The storage locations of some medicines including gliclazide, quetiapine and methotrexate were highlighted and were well separated from other medicines to reduce the risk of picking errors.

The pharmacy got its medicines from licensed wholesalers and unlicensed 'specials' were obtained from specials manufacturers. No extemporaneous dispensing was carried out. The pharmacy routinely experienced several stock shortages which were outside of its control. However, the team members emailed local surgeries to make them aware and arrange alternative medicines where possible.

Medicine stock for dispensing was stored in an orderly fashion in the dispensary. Pharmacy-only medicines were stored out of reach of the public.

The pharmacy checked the expiry dates of its stock regularly and kept a record about these checks. Short-dated items were identified to alert staff and reduce the risk of supplying when no longer in date. And there was a process to remove these from dispensing stock at a suitable time. When a sample of medicines was checked at random, there were no date-expired medicines found. Medicines were largely kept in appropriately labelled containers though one container had a handwritten label which did not include the manufacturer's details. The pharmacy technician agreed to made sure this was added in future. Out-of-date medicines and patient-returned medicines were transferred to designated bins. These were stored away from other medicine stock and were disposed of through licensed waste contractors. There were processes followed to denature CDs before disposal. Appropriate arrangements were in place for storing CDs and access to the CD cabinets was well-controlled.

There was ample storage capacity for medicines requiring cold storage. Temperature ranges for the four pharmacy fridges were checked regularly to make sure they remained suitable for storing temperature-sensitive medicines. The records seen were within the appropriate range of between 2 and 8 degrees Celsius. The pharmacy was informed about drug recalls and safety alerts through company communications and there was a process in place to make sure the pharmacy responded to these promptly.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. It keeps its equipment clean. And it has processes to make sure its equipment is safe and effective to use.

Inspector's evidence

The pharmacy had measuring and counting equipment of a suitable standard to use when dispensing and providing other services. The medicine measures seen were clean. However, the pharmacy was re-using a plastic syringe for measuring volumes less than 10mls. The team said a glass measure was on order.

There was suitable equipment for disposing of sharps waste and clinical waste arising from vaccination services and 'Our Future Health' and this was stored safely. There were also adrenaline and syringes readily available in the event of anaphylactic reactions associated with vaccination services.

The pharmacy had a range of up-to-date reference sources available for providing advice and clinical checks. All electrical equipment appeared to be in good working order and was tested regularly. Patient medication records were stored electronically and access to these was password protected. NHS smartcards to access summary care records and electronic prescriptions were not shared. Screens containing sensitive information were not visible to the public. The staff had access to cordless phones and could move to quiet areas of the pharmacy to make phone calls out of earshot of waiting customers.

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.