General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 18 Fremlin Walk, MAIDSTONE, Kent, ME14 1QP

Pharmacy reference: 1090034

Type of pharmacy: Community

Date of inspection: 21/04/2023

Pharmacy context

The pharmacy is in a busy shopping precinct in Maidstone town centre. It provides an NHS dispensing service. And additional services, including the New Medicine Service, flu vaccinations, blood pressure checks and emergency hormonal contraception against a Patient Group Direction. 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. The pharmacy receives most of its prescriptions electronically.

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 is good at recording and reviewing mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk.
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 identifies and manages the risks associated with its services to help provide them safely. And team members understand their role in protecting vulnerable people. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help minimise any future risk and help make its services safer. The pharmacy regularly seeks feedback from people who use the pharmacy. And it largely keeps its records up to date, but it doesn't always ensure that its responsible pharmacist record is completed correctly.

Inspector's evidence

Up-to-date standard operating procedures (SOPs) were available online. And team members had signed to show that they had read, understood, and agreed to follow them. The pharmacist explained that she highlighted any dispensing mistakes she identified during the checking process (near misses) to the team member involved where possible. That team member would then be responsible for identifying and rectifying their near misses. Team members recorded any near misses, and these were reviewed regularly for any patterns. The outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. 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 pharmacy highlighted drawer fronts where these medicines were kept. Following a recent review of the near misses, team members were reminded to carefully check the name on the top of each prescription so that they only dispensed one person's medicines at a time. The pharmacist explained the process for dealing with a dispensing error, where a dispensing mistake had reached a person. These were recorded on designated form and a root cause analysis was undertaken. A recent error had occurred where two people's medicines had been bagged together and handed out. Team members had to re-read the 'handing out' SOP and were reminded to check each prescription against the bag label before handing over the items. All dispensing errors were reported to the pharmacy's head office.

Workspace in the dispensary was limited but it was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Team members routinely used plastic tubs were used to minimise the risk of medicines being transferred to a different prescription. And they initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacy routinely used pharmacist's information forms (PIF) to ensure that important information was available throughout the dispensing and checking processes. A 'quad stamp' was printed on prescriptions and dispensing tokens. Team members initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out).

The store would open if the pharmacist had not turned up in the morning, but the registered pharmacy area would remain closed. One of the team explained that a notice would be displayed to inform people and the pharmacy's head office would be notified. Team members knew what tasks they should not undertake if the responsible pharmacist (RP) was signed in but not on the registered premises. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular

intervals. And the private prescription records were completed correctly. The nature of the emergency was not always recorded when a supply of a prescription-only medicine was made in an emergency without a prescription. The right RP notice was clearly displayed, and the RP record was largely completed correctly. There were a few occasions where the record had not been completed and the pharmacy had been open. And there were several entries where the pharmacist had not signed out and there had been a different pharmacist working the following day. This was discussed with the pharmacist during the inspection, and she said that she would remind people to complete the record when they finished their shift.

The pharmacy had its confidential waste removed by a specialist waste contractor. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. 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. And team members had undertaken training about protecting people's personal information. There were some dispensed prescriptions kept on the dispensary counter at the start of the inspection and these were potentially accessible to people using the pharmacy. This was discussed with the team and the filing system was moved during the inspection to a more suitable place in the dispensary.

The pharmacy regularly asked people for feedback by handing out 'how did we do?' cards. And the tills printed details about how people could provide feedback on some receipts. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The pharmacist said that the pharmacy's head office had received a complaint recently. The pharmacy had informed a person that their medicine was ready for collection, but it was not ready when they presented to collect it a day later. The pharmacy's head office had contacted the pharmacy to find out what had happened. The pharmacist had investigated it and had already apologised to the person. She had reminded team members to ensure that prescriptions were prioritised where needed so that they were dispensed in a timely manner.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken safeguarding training provided by the pharmacy's head office. The dispenser could describe the types of people who might be considered as vulnerable, and he said that he would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They work well together to ensure that the workload is well managed. And they are provided with some ongoing training to maintain their knowledge and skills. They can raise any concerns or make suggestions and can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, two trained dispensers and one trainee pharmacy adviser working during the inspection. The store manager was a trained dispenser and could provide cover where needed. 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. And this helped the pharmacy to keep up to date with its dispensing. The pharmacist said that the pharmacy was in the process of recruiting for a part-time position. Team members mentioned that the pharmacy was relying on locum pharmacists until around one month ago. The pharmacy now had a part-time pharmacist working three days a week and locums covered the other shifts.

The trainee pharmacy adviser had only been working at the pharmacy for around two weeks. She appeared confident when speaking with people and she asked people questions to establish whether a medicine was suitable for the person it was intended for. She regularly referred to the pharmacist or another more experienced team member throughout the inspection before selling any medicines.

Team members had access to online training modules provided by the pharmacy's head office. The pharmacist said that team members had to complete the modules in their own time due to the pharmacy's current workload. And the store manager was responsible for monitoring team training to ensure that any mandatory training was done within the required timeframe. The pharmacist was of the continuing professional development requirement for the professional revalidation process. She had recently completed some training about weight loss medicines. And she felt able to take professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacist said that team members generally passed on any important information to each other throughout the day. And there were informal morning huddles to discuss the plan for the day and allocate tasks. Team members felt comfortable about discussing any issues with the pharmacist and the pharmacist said that she would be open to suggestions on how improve the pharmacy's services. She said that all team members had regular appraisals and performance reviews. A target was set for the New Medicine Service. The pharmacist said that the pharmacy usually met the target, and she would not let it affect her professional judgement. And the pharmacy provided the services for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout which presented a professional image. And it was secured from unauthorised access. Pharmacy-only medicines were kept behind the medicines counter and screens were used to cover the shelves when the pharmacy was closed. And an extendable barrier was used to restrict access when the pharmacy was left unattended. 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 temperatures were suitable for storing medicines. There were several 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. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The consultation room was accessible to wheelchair users, and it was in the shop area. It was suitably equipped, and a curtain could be used to cover the glass door if needed. The door was not lockable and there were two in-use sharps bins on the floor in the room. This was discussed with the pharmacist during the inspection, and she said that she would ensure that these were removed. And she would enquire about getting a lock installed on the door. 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 provides its services safely and manages them well. And it dispenses medicines into multi-compartment compliance packs safely. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And it highlights prescriptions for controlled drugs to help minimise the chance of these being handed out after the prescription has expired. The pharmacy 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 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 people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. The pharmacy had robust procedures to ensure that people received their packs before 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. The pharmacy did not routinely request prescriptions for 'when required' medicines. People were contacted to see if they needed them when their packs were due. 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 pharmacy used coloured cards to highlight prescriptions for higher-risk medicines. The cards had prompt questions printed on the reverse to assist staff when handing these items out. The pharmacist said that she routinely checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. 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 (PPP). She explained that she would refer a person to their GP if they were not on a PPP and needed to be on one. Prescriptions for Schedule 3 and 4 CDs were highlighted. And dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that team members checked CDs and fridge items with people when handing them out. There were signed in-date patient group directions available for the relevant services offered.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. And it received drug alerts and recalls from its head office. The pharmacist explained how the pharmacy kept a record of any action taken for future reference. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and

medicines were kept in their original packaging. Fridge temperatures were checked daily, and the maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridge was suitable for storing medicines and was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. And denaturing kits were available for the safe destruction of CDs. The pharmacy ensured that returned CDs were promptly recorded in a register and these CDs were clearly marked and kept separated from stock CDs. There were two signatures recorded when the CDs were destroyed.

The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after five weeks. If a person had not collected any items from their prescription, it was returned to the NHS electronic system or to the prescriber. And the items were returned to dispensing stock where possible. 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.

Deliveries were made by delivery drivers. The pharmacy used an online booking system for deliveries and contacted the person before making the booking to check that they would be at home. The delivery driver obtained people's signatures for deliveries where possible using a hand-held electronic device so that another person's information was protected. Any undelivered items were returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

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

Triangle tablet counters and suitable equipment for measuring liquids were available and clean. Separate measures were marked for used with certain medicines only. And 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. There were up-to-date reference sources available in the pharmacy and online. The pharmacist said that the blood pressure monitor was replaced in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.