General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2, Riverside Retail Park, Ten Perch Road Wincheap, CANTERBURY, Kent, CT1 3TQ

Pharmacy reference: 1092467

Type of pharmacy: Community

Date of inspection: 22/04/2021

Pharmacy context

The pharmacy is located in an edge of town retail park in Canterbury. It is a midnight pharmacy and open 100 hours a week. The pharmacy provides a range of services, including the New Medicine Service, and seasonal flu vaccinations. The pharmacy does not offer a delivery service or provide medicines as part of the drug treatment services. The inspection was carried out during the Covid-19 pandemic.

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
1. Governance	Standards met	1.2	Good practice	The pharmacy 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.
2. Staff	Standards met	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 help 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

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It is good at recording and regularly reviewing any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. The pharmacy shares its learnings with other pharmacies in the company. It protects people's personal information and people can provide feedback about the pharmacy and its team. Team members understand their role in protecting vulnerable people. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. And the workplace risk assessments in relation to Covid-19 had been carried out. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Medicines which looked alike or sounded alike were highlighted and 'select and speak' cards were used to remind team members to read aloud the name of the medicine while selecting it. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The dispenser confirmed that there had not been any recent dispensing errors, but previous ones had been discussed with the team. The outcomes from the reviews of near misses and dispensing errors were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group.

Workspace in the dispensary was limited, but it was free from clutter. And there was an organised workflow which helped staff to prioritise tasks and manage the workload. Plastic tubs 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.

Team members' roles and responsibilities were specified in the SOPs. And team members had signed to show that they had read, understood and agreed to follow the SOPs. The dispenser explained that the pharmacy team arrived at the pharmacy around an hour before the pharmacy store was due to open. If the pharmacist had not turned up, she would attempt to contact the pharmacist and failing that, she would contact the pharmacy's head office to arrange cover if needed. The dispenser knew that she should not carry out any dispensing tasks until there was a responsible pharmacist (RP). And she knew that she should not hand out any dispensed items or sell any pharmacy-only medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were

filled in correctly, and the CD running balances were checked at regular intervals. Any liquid 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.

Other records largely complied with the requirements. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely 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.

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. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had previously carried out yearly patient satisfaction surveys, but this had not been undertaken recently due to the ongoing pandemic. Results from previous surveys were available on the NHS website, and these were positive overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The dispensers had both undertaken CPPE level 1 safeguarding training. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. They confirmed that there had not been any safeguarding concerns at the pharmacy. 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. It is good at providing its staff 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 are able to 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 are able to take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was a provisionally registered pharmacist (who was acting as the RP) and two trained dispensers working at the pharmacy at the time of the inspection. One of the dispensers had recently passed the NVQ Level 3 pharmacy course and was in the process of applying to register as a pharmacy technician. 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 inspector discussed with the dispenser about the reporting process in the event that a team member tested positive for the coronavirus.

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

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had been concentrating on preparing for the upcoming registration exam and had been allowed time away from work to do this. One of the dispensers talked about the online training available at the pharmacy. He said that he was allowed 30 minutes each week to complete any training, and this was monitored by the pharmacist. The team members discussed any dispensing mistakes openly during the team meetings. They also talked about any issues and information from the pharmacy's head office. The pharmacist felt able to take professional decisions.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser said that she had worked at the pharmacy for around six months and had been supported with her coursework for the dispenser course.

Targets were set for the New Medicine Service and the pharmacist said that the pharmacy had recently reached the set target. She did not let the targets affect her professional judgement and carried out the service for the benefit of people who had been prescribed a new medicine from the list.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was secured from unauthorised access. After the main store closed at 7pm, people wanting to use the pharmacy used a hatch at the front of the shop. The pharmacy was bright, clean and tidy throughout, and this presented a professional image. Pharmacy-only medicines were kept behind the counter. 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 temperature was suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

See-through screens had been installed at all counters to help minimise the spread of infection. There were marked areas on the floor in the shop area to help people maintain a suitable distance from each other. There were two stools available in the shop area for people to use. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy's main consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. A small screen had been installed on the table to help minimise the spread of infection when people were using the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and it manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls and keeps a record of any action taken. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The dispensary was to the rear of the store and team members working in this area did not have a clear view of the main entrance. But there were several team members working in the shop area who could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy provided Covid-19 Self-Test (Rapid Antigen Test) kits and team members completed the necessary paperwork after asking the relevant questions.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispenser said they checked Schedule 2 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 pharmacy had the relevant patient information leaflets and warning cards available, and most manufacturer's packs came with a warning card attached. Prescriptions for higher-risk medicines such as methotrexate or warfarin were highlighted, so there was the opportunity to speak with these people when they collected their medicines and check that they were taking them properly. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines, but a record of blood test results was not routinely kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

Printed pharmacist information forms with important information remained with the prescriptions throughout the dispensing process. The pharmacist said that having the information printed at the time the prescription was processed had helped with the dispensing process as the team had previously had to write the information on a form which was time consuming. 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).

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 three months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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. Uncollected prescriptions

were checked weekly using a colour-coded retrieval system. 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.

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, and two signatures were recorded.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The dispenser explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference and this made it easier for the pharmacy to show what it had done in response.

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 use with certain medicines. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The weighing scales in the consultation room were in good working order. And the body mass index machine in the shop area was calibrated by an outside agency. There was a notice asking people to wipe the machine before and after use to help minimise the spread of infection. And wipes were available next to the machine. Team members wore masks while at work and hand sanitiser was available.

Fridge temperatures were checked twice a day, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. Guidance was available for team members to follow, if the temperature was found to be outside of the recommended range.

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.