General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Aylesham Health Centre, Queens Road, Aylesham, CANTERBURY, Kent, CT3 3BB

Pharmacy reference: 1098063

Type of pharmacy: Community

Date of inspection: 12/04/2023

Pharmacy context

The pharmacy is located within a health centre in a largely residential area. It provides a range of services, including, the New Medicine Service, stop smoking, weight loss, blood pressure (BP) checks, health MOT (BMI, BP, height and weight) and flu vaccinations. It also provides medicines as part of the Community Pharmacist Consultation Service. 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	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

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It regularly seeks feedback from people who use the pharmacy. And one the whole, it keeps its records up to date and accurate. Team members understand their role in protecting vulnerable people. And the pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information and shares it with other pharmacies in the group to help make its services safer and reduce any future risk. The pharmacy protects people's personal information well.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs), and team members had signed to show that they had understood them and agreed to follow them. Team members were responsible for identifying and rectifying a near miss (a dispensing mistake identified before the medicine had reached a person) after it had been highlighted to them. Near misses were recorded and reviewed regularly for any patterns. And the outcome from the reviews were discussed openly during the regular team meetings. The pharmacy stored items in similar packaging or with similar names separately where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had been an increase in the number of near misses recorded. This was due to team members now recording mistakes made which were discovered before they had reached the pharmacist or accuracy checking technician (ACT). And this had helped the pharmacy to identify patterns. The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. Any dispensing errors were recorded on a designated form and a root cause analysis was undertaken. The pharmacy's head office was informed and learning points were shared with other pharmacies in the group.

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. And there were separate areas for dispensing and checking medicines. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. 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). The ACT knew that she should not check items if she had been involved in the dispensing process. And that she should only check ones that had been clinically checked by the pharmacist. Pharmacist's information forms were routinely used to ensure important information was available throughout the dispensing and checking processes.

Team members' roles and responsibilities were specified in the SOPs. A team member said that the pharmacy would not open if the pharmacist had not turned up in the morning. A notice would be displayed to inform people that a pharmacist was not available and team members knew which tasks should not be undertaken. And team members knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was signed in, but they were not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) record was completed correctly, and the right RP notice was clearly displayed.

Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The private prescription records were mostly completed correctly, but the correct prescriber's details were not always recorded. 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. The pharmacist said that she would ensure that these were recorded in future.

Team members had completed training about protecting people's personal information. Confidential waste 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. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. People using the pharmacy were given 'How did we do?' cards and asked to complete an online survey about the pharmacy's services. The till randomly printed details about how people could provide feedback about the pharmacy. Team members said that there had not been any recent complaints. And the pharmacy's head office would inform them about any that they received.

Team members had completed training about protecting vulnerable people. And they could describe potential signs that might indicate a safeguarding concern. The team said that there had not been any safeguarding concerns at the pharmacy, and they would refer any concerns to the pharmacist. 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. They are provided 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 can 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 can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one ACT and two trained pharmacy advisers (one was enrolled on the NVQ level 3 pharmacy course) working during the inspection. The pharmacist said that all team members employed by the pharmacy had either completed an accredited course for their role or they were undertaking appropriate training. The team members wore smart uniforms with name badges displaying their role. They communicated effectively with each other throughout the inspection to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. One of them when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She knew which questions to ask to establish whether an over-the-counter medicine was suitable for the person it was intended for.

Team members had access to online training modules provided by the pharmacy's head office. The pharmacist said that she and the pharmacy's area manager monitored team member's training records to ensure that all necessary training was undertaken in a timely manner. Team members were allocated protected training time each week which allowed them to complete the training at the pharmacy. They could also access the online training at home if they preferred. Team members were in the process of reading the updated SOPs. The pharmacist and ACT were aware of the continuing professional development requirement for the professional revalidation process. The ACT had recently completed training to become an authorised witness for CD destruction and to be a workplace supervisor. She had also undertaken recent training about the flu vaccination service and blood pressure checks. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she felt able to take professional decisions.

Team members had informal morning huddles to discuss any issues and allocate tasks for the day. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacy received a monthly professional standards newsletter from the pharmacy's head office. Team members discussed these during their regular team meetings, and they signed the newsletters to show that they had read and understood them. The pharmacist said that the area manager regularly visited the pharmacy to discuss any ongoing issues and provide support where needed. Targets were set for the New Medicine Service and the hypotension service. The pharmacist said that there was a certain amount of pressure to achieve the targets, but she would not let them affect her professional judgement.

Most team members had appraisals and performance reviews every six months and the pharmacist said that hers was every quarter. The team had individual future development plans, and these were reviewed regularly. One team member was being encouraged to become an ACT and then possibly a store manager. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Following feedback from team members, the pharmacy had changed its bagging process which had helped to minimise the time it took for team members to hand out bagged items to people. And the pharmacy had also archived a lot of its paperwork to make more room available in the dispensary.

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. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were largely kept behind a narrow standalone medicines counter. But there was no barrier either side of the counter or a sign to discourage people from selecting some of the medicines themselves. Team members said that there had been several occasions where people had come behind the counter to access the medicines and they had to be stopped by a member of staff. The pharmacist said that she had been in contact with the pharmacy's head office to request a barrier. She was in the process of ordering suitable ones and would get them fitted promptly. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were two 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. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available. There were a few damaged drawers in the dispensary, and these were not being used. These had been reported to the pharmacy's head office and were due to be replaced.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and 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. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines and team members speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and 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 induction hearing loop appeared to be in good working order. And the pharmacy could product large-print labels for people who needed them. There was a shelf at the counter which was at a suitable height for people in wheelchairs to use if needed.

Prescriptions for higher-risk medicines were highlighted using coloured cards. There were prompt questions were printed on the reverse of the cards to assist staff when handing these items out. The pharmacist said that she 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 patient's medication record. Prescriptions for Schedule 2 and 3 CDs were highlighted with the date not to be handed out after. The pharmacist explained that when a CD prescription was scanned on the pharmacy's computer system, it showed the date that the prescription was due to expire. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members checked 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 (PPP). The pharmacist explained that prescriptions for these medicines were usually annotated if a person was on the PPP. And she would refer a person to their GP if they were not on a PPP and needed to be on one.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. And items due to expire within the next several months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. CDs that people had returned, and expired CDs were clearly marked and kept separated. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

Part-dispensed prescriptions were checked regularly. '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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked

weekly, and people were sent a text message reminder if they had not collected their items after a few weeks. They were then allowed a further week to collect their medicines. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

Deliveries were made by delivery drivers. The delivery drivers signed to show that they had taken the items and used a hand-held electronic device to record people's signatures. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. 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 and tablet counters were available and clean. A separate counter was marked for cytotoxic use only which 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.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor would be replaced in line with the manufacturer’s guidance. The weighing scales were in good working order. And 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.