General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit E, Congleton Retail Park, Barn Road, CONGLETON, Cheshire, CW12 1LJ

Pharmacy reference: 1108086

Type of pharmacy: Community

Date of inspection: 08/08/2024

Pharmacy context

The pharmacy is in a retail park on the outskirts of Congleton in Cheshire. Its main activities include dispensing NHS prescriptions, private prescriptions and selling over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs to help people take their medicines at the right times. And it provides a range of NHS services such as NHS Pharmacy First and seasonal flu vaccinations. It delivers some medicines to people's homes.

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 suitably identifies and manages the risks with its services. It has up-to-date written procedures for team members to follow to help them provide services safely. And it keeps accurate records as required by law. Team members record and learn from mistakes they make whilst dispensing. They mostly keep people's confidential information secure. And they have the knowledge and support tools to help vulnerable people access care.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) relevant to its services, which were accessible online and through individual team member's training platform access. These included for dispensing, controlled drug (CD) management and high-risk medicines. The SOPs checked were dated 2023 and 2024. The pharmacy had recently amended processes involving dispensing and handout of medicines and the team had read the updated amendment to the SOP. A pharmacist accessed their training records for SOPs, which were up to date. Team members read updated SOPs monthly and received reminder emails when they had outstanding SOP training modules to complete. And they completed a short quiz to assess their understanding.

The correct Responsible Pharmacist (RP) notice was displayed, and team members were aware of their roles and responsibilities. They were observed working within their roles during the inspection, offering advice to people and referring to the pharmacist when required. They understood what tasks could and couldn't be completed before a pharmacist signed in as RP.

Pharmacy team members recorded some near miss errors each month. These were mistakes identified during the dispensing process. The records were mainly about what had happened, rather than actions and any learning documented. The patient safety champion, who was one of the dispensers, used the information from near miss errors and dispensing incidents to produce a monthly patient safety report. Dispensing incidents were errors identified after the person had received their medicines. Recent patient safety reports encouraged team members to record more of their near miss errors and it highlighted the most common mistake was incorrect quantity dispensed. Due to the pharmacy's extended opening hours, it was difficult to have a meeting to discuss findings from the patient safety report with all team members present. The findings were displayed on a notice board and shared by group instant messaging, but it was felt that more could be done with the team to improve recording and group learning. They received communications from head office about errors that had occurred in other pharmacies in the company. This allowed the team to learn from these mistakes.

The pharmacy had a complaints procedure, and a dispenser was clear about their role in handling complaints. They knew when to refer to the RP and when and how to escalate this further to area management and head office. The pharmacy had current professional indemnity insurance. From a sample seen, the records required by law were completed correctly, including CD register entries, private prescription records and RP records. The team checked the quantity of CDs against the balance in the register weekly and recorded these checks. For two CDs checked, the physical stock was correct against the register balance. The pharmacy had a patient-returned CD destruction register, and entries were made on receipt of the returned CDs.

The team completed training on General Data Protection Regulation (GDPR) and knew how to protect

people's privacy and confidential information. They mostly kept all people's confidential information in the dispensary, visible only to pharmacy staff. They separated confidential waste, which was collected by a third-party contractor. Both pharmacists working on the day of the inspection had completed safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE), one pharmacist to level 3.

The pharmacy had a safeguarding policy and team members understood their role in helping vulnerable people. They described if they had any concerns over vulnerable people they would speak with the RP. Local safeguarding contact details, suicidal referral telephone numbers and support group contact details were available to refer to. The pharmacy advertised the consultation room as a safe space, which supported people experiencing domestic abuse. The team had knowledge about the service but had not had the need to use it.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the training, skills, and experience to manage the workload safely and effectively. They complete regular training, relevant to their role, to keep their skills up to date. And they feel confident to raise professional concerns should they need to.

Inspector's evidence

The pharmacy was open extended hours over seven days a week. There were two pharmacists on duty, one of whom was an employed relief pharmacist working at the pharmacy two days a week. And the other, the RP, was an employed pharmacist working three days a week. They were working with three dispensers. A field-based pharmacy support manager was present, who had recently been giving regular support to the pharmacy since the pharmacy manager had left. There was also a vacancy for an accuracy checker, but the pharmacy was finding it difficult to recruit one. There were three other dispensers and another regular part-time pharmacist employed but not working on the day of the inspection. The three pharmacists covered the opening hours between them in regular shift patterns and relief pharmacists, or locum pharmacists covered annual leave. There was a whistleblowing policy, which team members knew how to access if they needed to. And they knew how to raise professional concerns. Team members were seen explaining tasks that needed doing with each other and the workload appeared to be up to date. The dispensing of medicines into multi-compartment compliance packs was managed well and up to date. There was a queue of people waiting to be seen for much of the time during the inspection, but this was professionally managed by the team member who was polite and knowledgeable in their role.

The pharmacy had a wide range of online training modules for its team members to complete. This included for services, SOPs, and new product training. A pharmacist demonstrated their online company training record, which showed they completed regular learning. And there were certificates of training for both team members and pharmacists, for example for safeguarding. The team had access to NHS e-learning for healthcare (elfh) and one of the pharmacists had recently used it to complete sexual health contraceptive e-learning. A couple of team members discussed how they used their professional judgement when making sales for medicines liable for misuse, for example codeine-containing medicines. This included giving advice on the dose, side effects and the maximum length of time to take these medicines before consulting a GP. When they had concerns about a sale, including for repeat requests, they referred to the RP, who provided additional support and advice. Team members were comfortable discussing mistakes they made but they did not discuss these all together due to working patterns. This made it more difficult to discuss ways to improve ways of working. The monthly patient safety report was available on the notice board for team members who had not been at the meeting. The pharmacy team had no concerns over targets set, and they were meeting them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the services provided. They are clean, secure, and hygienic. Team members use a good-sized, soundproof consultation room for people to have private conversations and access services.

Inspector's evidence

The pharmacy premises were at the back of a Boots retail store and access to the dispensary was restricted by tensor barriers and by the presence of team members. The pharmacy had recently had a refit and there were additional computer monitors and storage to help with increased dispensing workload. There was adequate bench space for dispensing. A team member was seen working neatly and using available bench space efficiently when dispensing into multi-compartment compliance packs. The team made effective use of the shelving above the benches to store medicines awaiting checking to avoid clutter on the benches.

The pharmacy was clean, secure, and hygienic. There was a full height wall across part of the dispensary, which allowed privacy for dispensing. The layout allowed the pharmacist to supervise team members who were handing out medicines, providing advice and selling medicines. The dispensary floor was clear. The pharmacy team had access to staff facilities and use of a secure office. There was hot and cold running water for handwashing and the preparation of medicines. Lighting was bright and the temperature was acceptable. There was a spacious and tidy consultation room, which was soundproofed for confidential conversations and suitable for the provision of services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and delivers these services safely. The pharmacy uses technology to help team members provide suitable advice to people collecting their medicines. It obtains medicines from recognised sources, and team members store and manage them appropriately. They conduct regular checks to help make sure medicines are in good condition and safe to supply to people.

Inspector's evidence

There was plenty of parking and the store had level access from the pavement outside. The pharmacy was situated at the rear of the store and was clearly signposted. Opening times were advertised. The pharmacy area had healthcare leaflets and posters displayed to help people access services. There was no signage to indicate there was a consultation room, so usage relied on team members advertising it. The pharmacy provided the NHS Pharmacy First Service and had regular requests. There were up-to-date patient group directions (PGDs) for the service's treatment pathways. The pharmacy dispensed several private prescriptions per week, most received electronically from the company's associated online doctor service. This included for weight loss medicines. The pharmacy didn't check people's weight and height when they collected their medicines, and they didn't have access to the body mass index (BMI) on the prescription. The pharmacist explained how they would intervene if they had concerns but there wasn't a formal process to make any checks when the person collected. So, the pharmacy may miss opportunities to complete an independent verification of weight and height to check suitability of treatment and to formalise the provision of healthy lifestyle advice.

The pharmacy delivered medicines to people's home for a one-off or yearly charge. The team entered details of the deliveries on to an electronic platform, and a driver was allocated to the pharmacy to complete these deliveries. The pharmacist also kept a written copy of the deliveries, which the driver signed. This meant in addition to the electronic record, there was a paper record kept in the pharmacy of which deliveries were made by which driver, which helped manage any queries.

The pharmacy had safeguards in place to reduce risk in the dispensing process. This included using plastic tubs to hold people's prescriptions and medicines together. They initialled the dispensed by and checked by boxes on dispensing labels to keep an audit trail of which team members had been involved. Team members used a handheld device to scan a barcode on the person's medicine bag, before handing it out to people. The handheld device prompted team members to provide advice and to complete a series of patient-safety questions before handing out. This included for higher-risk medicines such as warfarin with questions such as when the person last had an INR blood test, and questions relating to the pregnancy prevention programme for people taking valproate. Team members were required to confirm people taking methotrexate were doing so as a weekly dose. This had replaced the use of laminate cards in the dispensing process, although a laminate to highlight when pharmacist advice was required was still available. Some prescriptions were assembled at the company's offsite hub pharmacy to help manage the dispensing workload. The pharmacist completed the clinical check and accuracy check of the prescription data prior to submitting to the hub pharmacy. The team had knowledge about the pregnancy prevention programme for valproate. The pharmacist described an audit the pharmacy had completed, which had identified the pharmacy didn't dispense valproate to people who may become pregnant. The team was aware of the requirement to dispense valproate in the original manufacturer's pack.

The pharmacy team dispensed some medicines into multi-compartment compliance packs, and they wore gloves to protect themselves when handline medicines. The process was organised, with prescriptions ordered in advance, so there was time to resolve any queries. The dispensing workload was up to date and the packs were ready in advance of people needing them. There were record cards, neatly completed, detailing people's current medication, dosage, and administration times. These were used alongside prescriptions throughout the dispensing and checking process. The dispenser annotated the packs with descriptions of what the medicines looked like so they could be identified in case of queries and patient information leaflets were supplied alongside the packs. An additional check of the number of medicines in each compartment before sealing the pack had reportedly reduced the number of errors. The pharmacy attached labels to the front of the pack, which detailed people's additional current medication that was not included in the pack, for example insulin. This meant on admission to hospital the staff had a list of all current medication to help avoid omissions in treatment.

The pharmacy obtained medicines from recognised wholesalers. Pharmacy-only (P) medicines were displayed behind the pharmacy counter, to help the pharmacist supervise sales. CDs were held securely, and the team kept out-of-date CDs separated from in-date stock. Team members used a date checking matrix and they held up to date, signed records of the medicine expiry date checks they made. They annotated liquid medicines with the date of opening. Medicines were stored neatly in dispensary drawers and a sample checked were found to be in date. The pharmacy had two medical fridges, and there were records of daily temperature checks showing them to be within the required range. The temperatures of both fridges were in range during the inspection. The pharmacy team received an electronic notification of safety alerts and medicine recalls. There were records of recent alerts signed and dated with the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Team members have access to the equipment they need to provide the pharmacy's services and to keep people's confidential information secure. And the pharmacy maintains and replaces its equipment so that it is suitable to use.

Inspector's evidence

The pharmacy had equipment it needed, including a range of clean, glass measuring cylinders used for dispensing. And it had two blood pressure monitors to support the pharmacy's hypertension service, which the pharmacist confirmed were replaced by head office automatically. The team had access to reference resources, the internet and company resources for up-to-date information on services and for clinical information.

The pharmacy stored dispensed medicines awaiting collection on shelves behind the handout area. This prevented people in the retail area seeing confidential information on prescriptions and on name and address labels on bags. Computer screens were positioned so unauthorised people couldn't see any confidential information. Computers were password protected, and use of NHS Smart cards controlled access to people's confidential information.

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.