General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 82-86 The Luton, Arndale Centre, LUTON, Bedfordshire, LU1 2BG

Pharmacy reference: 1028873

Type of pharmacy: Community

Date of inspection: 25/04/2024

Pharmacy context

The pharmacy is in a shopping centre in central Luton. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. Its services include care home services, delivery, blood pressure case-finding, seasonal flu vaccinations and Pharmacy First.

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’s working practices are safe and effective. The pharmacy's team members record and discuss mistakes to learn from them and help stop the same mistakes happening again. They follow clearly written instructions to help them identify and manage risks when they are providing services. They highlight prescriptions for high-risk medicines so they can make sure people use them properly. The pharmacy keeps the records it needs to show that medicines are supplied safely and legally. The pharmacy team members protect people’s private information and understand how they can safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes on the pharmacy’s online reporting system. They reviewed and discussed the near misses regularly to learn from and reduce the chances of the same mistakes happening again. And there was a near miss champion leader to monitor patterns and trends of near misses. Team members explained that medicines involved in incidents or were similar in some way were generally highlighted or separated from each other in the dispensary. The pharmacy team had arranged medicines stock to assist the dispensing process. The monthly patient safety review was completed and the team was encouraged read it. A member of the pharmacy team explained that with the introduction of the current computer system, the prescription barcodes and medicine pack bar codes were scanned as part of the dispensing process. If a member of the team picked and scanned an incorrect item, the computer alerted the team. This function had reduced the number of mistakes in the dispensing process.

Members of the pharmacy team responsible for making up people’s prescriptions used tubs to separate each person’s medication and to help them prioritise their workload. They checked prescriptions were signed by the prescriber, in date and assigned a waiting time. Associated paperwork was kept together in the tub with the medicines until the final check. A member of the team completed a pharmacist’s information form (PIF) for each person’s prescription to alert the pharmacist to allergies, interactions between medicines, high-risk medicines and outstanding medication when checking the prescription. The pharmacy team added colour-coded laminated cards highlighting high-risk medicines to prompt counselling by the pharmacist and therapeutic monitoring. Team members referred to the prescription when labelling and picking products. They scanned the barcode on each pack of medication and the pharmacy computer system alerted them to packs of medicine selected incorrectly. Each pack was scanned rather than scanning one pack and multiplying by the prescribed number of packs. Team members checked patient details when bagging the labelled medicines. Prescriptions being collected later were scanned and allocated a location in retrieval, and a text was sent to the person. Prescriptions were scanned out on collection. The team contacted people about prescriptions not collected and then followed a procedure to clear uncollected prescriptions and return the medicines to stock.

The team initialled dispensing labels to identify who dispensed and checked the medicines. Each prescription was initialled by the team members to show who entered data, dispensed, checked and handed out the medicines to people. Assembled prescriptions were not handed out until they were clinically and accuracy checked by the pharmacist. The responsible pharmacist (RP) checked

interactions between medicines prescribed together and interventions were recorded on the patient medication record (PMR). The RP explained that the prescriber would be contacted if necessary, by phone or email and a record was attached to the PMR for future reference.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last visit. Members of the pharmacy team read and signed SOPs relevant to their role to show they understood them and would follow them. One member of the team explained how they verified someone's identity before handing out prescription medicines. And a member of the team explained the sales protocol for selling pharmacy only (P) medicines. The pharmacy's head office monitored training completed in the SOPs. Members of the pharmacy team understood what they could and could not do, what they were responsible for and when to seek help. A trainee team member explained that prescriptions would not be given out or P medicines sold if the pharmacist was not on the pharmacy's premises. The pharmacy had a complaints procedure and people using the pharmacy could provide feedback via cards distributed by the team, online or via QR codes at the counter. The store manager read feedback and team members were rewarded.

The pharmacy's head office produced a regular bulletin of patient safety information which the pharmacy team members read and signed. The pharmacy completed risk assessments for the services it provided such as flu vaccination service and the NHS Pharmacy First Service (PFS) which was signed off by the store manager who checked it complied with NHS requirements. It had identified changes to team members' work patterns to manage core business alongside PFS. And assessed the suitability of the consultation room. Members of the pharmacy team had liaised with local surgeries. The pharmacy team had completed clinical audits required by the pharmacy quality scheme (PQS) and a clinical audit of people taking valproates. They were aware of the new rules for dispensing valproates and supplying them in original packaging.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The RP who signed in for the day also recorded fridge temperatures and completed the CD key log. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained controlled drug (CD) registers, kept the entries up to date and checked the stock levels recorded in the registers weekly in line with the CD SOPs. A random check of the actual stock of one CD matched the recorded amount. There were some loose leaves in the CD register which may be at risk of being mislaid. The pharmacy kept records for the supplies it made by private prescription. Emergency supplies were from NHS 111 and records were maintained on PharmOutcomes.

The pharmacy was registered with the Information Commissioner's Office. Its team completed information governance training and made sure people's personal information could not be seen by other people and was disposed of securely. Members of the team used their own NHS smartcards and had their own log-in details to use the pharmacy computer. The pharmacy had a safeguarding SOP filed with the RP log and the team had completed safeguarding training. The RP had undertaken level 3 safeguarding. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. They are able to provide feedback about how they can improve the pharmacy's services. The pharmacy encourages and supports team members to undertake ongoing learning relevant to their roles and keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team had two pharmacists, five pharmacy assistants (PAs) who were accredited or in training, and two part-time registered pharmacy technicians. PAs were trained to dispense and sell medicines over the counter (OTC). The pharmacy team members covered each other's absences when needed but tried to limit how many people were on annual leave together. The pharmacy team followed a rota for breaks and the pharmacy sometimes closed for lunch. It put up a notice to warn people in advance.

The pharmacy team members were provided ongoing training and they could access training topics such as the SOPs relevant to their role. Team members read the SOPs for care home services as well as the pharmacy SOPs so they could switch roles if required. The pharmacy's head office maintained training records for members of the team. They had recently completed modules on managing antibiotic medicines and general data protection regulation (GDPR). The team members had protected learning time to complete accredited training. SOPs were available in hard copy and online and the pharmacist sometimes asked questions to test team members knowledge and understanding of the SOP. The team completed mandatory training such as information governance and PQS topics. Members of the team worked well together to serve people quickly and process their prescriptions safely. The pharmacy had an OTC sales procedure for members of the team to follow when people were buying medicines. They knew when to refer requests to a pharmacist. The pharmacists' training to deliver the PFS included triaging for when people presented with symptoms and they were able to recommend treatment or signpost them elsewhere.

The team had ongoing appraisals with the store manager to monitor training needs. Team members had a regular huddle to allocate which section they would cover in line with planners. Team members could provide feedback and had suggested a way of offering to measure people's blood pressure during a consultation for another service. The pharmacy also had a whistle-blowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright, clean and suitable for the provision of healthcare. The pharmacy is secured when it is closed to protect people’s private information and keep the pharmacy’s medicines safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The public area of the pharmacy was much larger in area than the dispensary and there were chairs for people who were waiting. The medicines counter and the dispensary were both on the same level at the back of the retail area and people had access to a consultation room which protected their privacy. The consultation room walls displayed posters explaining how to deal with needlestick injury and fainting. The pharmacy had a health information display. Members of the pharmacy team cleaned and tidied the pharmacy’s premises and records were maintained of cleaning routines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team makes sure pharmacy services are easily accessible to people with different needs. And its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources so they are fit for purpose. Pharmacy team members pro-actively highlight prescriptions for high-risk medicines and make sure people get the information they need to use their medicines safely. They store medicines securely at the right temperature and they keep records of regular checks to show medicines are safe to use. The team knows what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had a wide entrance which was level with the outside walkway in the shopping centre. This made it easier for someone who used a wheelchair, to enter the pharmacy. The pharmacy team members tried to make sure people could use the pharmacy's services. They could print large font labels so they were easier to read and there was a hearing loop to help people with difficulty hearing. Team members could speak or understand Arabic, Hungarian, Albanian, Jamaican, Urdu and Portuguese to help people whose first language was not English. And their name badges included a flag to identify the language. The pharmacy displayed information about available services.

Members of the pharmacy team signposted people to another provider if a service was not available at the pharmacy. There was a nearby clinic or they could call an ambulance. People could request their repeat prescription through the Boots App and track when it would be ready to collect. The pharmacy had a delivery service and prescriptions were stored on a different shelf in the dispensary. They were allocated a delivery slot and collected by a trained delivery person. There was an audit trail to track the prescription until it was delivered.

The pharmacists offered the new medicine service (NMS) to people to help them take their new medicines in the best way. The pharmacy computer flagged up new medicines prescribed for people. The pharmacists followed up the first conversation at set intervals in the pharmacy or by phone if the person preferred. And resolved problems such as side effects that might result in the person not taking their new medication.

Members of the pharmacy team added colour-coded laminated cards to prescriptions to highlight high-risk medicines and to prompt one of the team to speak to the person collecting them. Counselling on the best way to take the medicine was provided and any monitoring information such as blood tests was recorded on the patient medication record. The PAs were trained to give out prescriptions and check and record therapeutic monitoring values. For instance, the laminated card for supplying warfarin had questions on the reverse to ask the person collecting the warfarin. The team members were aware of the updated rules for dispensing and supplying a valproate. For instance, initiating treatment and follow-ups with the prescriber, and supplying the valproate in its original container.

The pharmacy provided care homes services in a dedicated area with a team of full-time and part-time dispensing assistants, registered pharmacy technicians and a pharmacist to oversee the service daily. The pharmacy supplied the medicines according to a matrix in their original manufacturer's packaging

which meant that tablets and capsules did not have to be popped out of their blisters to be repackaged in multi-compartment compliance packs. This was more hygienic and cut down on packaging and process. The care homes ordered their own prescriptions which were input into the computer system and checked for missing items. The list of missing items was communicated to the care home which liaised with the doctors' surgeries to supply the replacement prescriptions. Upon receipt, the pharmacy care home team reconciled the new prescriptions with their list. The team also dispensed interim prescriptions for acute medicines and new patients not yet set up on the matrix system. The risk to people was data entry which was usually minimised by scanning the barcode to obtain the prescription. The screen versus the prescription was cross-checked. And the team endorsed the prescription to reflect medicines with no barcode. A PIF was completed for the prescriptions for each medicine. And the team had introduced an extra check at the time of data entry. The pharmacy had a business continuity plan to ensure there would be little disruption to services in the event of an unforeseen event. The team would alert a nearby pharmacy and redirect EPS prescriptions.

The pharmacist clinically checked prescriptions before stock was ordered. Team members picked and labelled medicines. They placed checked items in a box which was signed and sealed so the care home received their order in a sealed box with an audit trail. The pharmacy supplied CDs within 28 days since the prescription was issued. It printed a medicines administration record (MAR) chart if required. The care homes returned unwanted medicines to the pharmacy. The care home service team members recorded their near misses and had identified a trend in quantity errors so the team had introduced an additional check to minimise these errors.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging and marked liquid medicines with a date of opening. The pharmacy team kept the dispensary benches clear as they bagged and stored completed prescriptions and put the medicines order away. They checked the expiry dates of all medicines stock according to a matrix and highlighted short-dated medicines. In a random check no date-expired medicines were found. The pharmacy stored its stock which needed to be refrigerated in fridges and kept records to show the temperature was between two and eight degrees Celsius. And it stored its CDs, securely in line with safe custody requirements. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. Records were maintained online and any affected stock was quarantined.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had marked glass measures to measure different liquids and it had fridges to store pharmaceutical stock requiring refrigeration. Its team regularly checked and recorded the maximum and minimum temperatures of the fridge. The blood pressure monitor was replaced annually and the pharmacy had a back-up monitor. The pharmacy recorded information relating to equipment checks. The electrical equipment was portable appliance tested (PAT). Equipment was cleaned between patients and cleaning records were kept. There were clinical waste bins and the team knew where the nearest defibrillator was located. The pharmacy had appropriate equipment such as an otoscope to provide the PFS.
Confidential wastepaper was disposed of securely. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they entered their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team and team members used their own NHS smartcards.

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.