General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 79-81 High Street, BROMLEY, Kent, BR1 1JY

Pharmacy reference: 1032616

Type of pharmacy: Community

Date of inspection: 10/10/2024

Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, NHS contraception service, blood pressure checks and uses patient group directions to provide the flu vaccination service. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

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 records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce future risks. And learning is shared throughout the company.
2. Staff	Standards met	2.2	Good practice	Team members undertake structured ongoing training to help keep their knowledge and skills up to date. And they get time set aside during work to complete it.
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

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

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. The pharmacy technician said that the dispensary would remain closed if the pharmacist had not turned up in the morning. She knew which tasks should only be undertaken when a responsible pharmacist (RP) was signed in. And she knew which tasks should not be undertaken if the RP was absent from the pharmacy.

Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong quantity of medicine had been supplied to a person. Following a root cause analysis, the pharmacy realised that the pack size for that medicine had recently changed. A dispensing incident report form had been completed, and the pharmacy's head office had been made aware. 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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were recorded and reviewed regularly for any patterns. The pharmacy had a team meeting following a recent review of the near miss record, to discuss the most common errors. Team members were reminded to check the strength of the medicine on the prescription before selecting the stock. The pharmacist said that there were fewer errors of this kind made the following month. Learning points from the reviews were also shared with other pharmacies in the group. And the pharmacy received a monthly newsletter highlighting common errors. The pharmacist said that the contents of the newsletter were discussed with the team.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was limited but it was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels 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 pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The private prescription records were completed correctly. And the nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled

drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was removed by a specialist waste contractor, computers were password protected and 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. And team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. The store manager said that the pharmacy had not received any recent complaints. She said that she would inform the pharmacy's head office if a complaint was received. And that the pharmacy's head office would let the pharmacy know if it received one. The till printed information on receipts at random intervals about how people could provide feedback. And there was a QR code at the dispensary counter for people to use. The store manager showed how she accessed any feedback online.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. Team members could describe potential signs that might indicate a safeguarding concern and 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. Team members are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. The team members are provided with time set aside for training and can complete it at work. They can raise any concerns or make suggestions and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe. And are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one pharmacy technician and one trainee pharmacy adviser working during the inspection. The store manager was a trained pharmacy adviser and said that she could help in the dispensary if needed. The store manager explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if 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 the pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. The trainee pharmacy adviser said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. And she was aware of the restrictions on sales of pseudoephedrine-containing products. Team members asked people relevant questions to establish whether the medicines were suitable for the person they were intended for.

The store manager said that team members read updated SOPs and completed assessments to show that they had understood them. The pharmacy's head office provided team members with regular online training modules. And this training was monitored by the store manager. Team members were allocated regular protected training time so that they could complete training at work. But they could also access the modules at home if they preferred. Team members had recently completed training about new medicines and the menopause.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. She had recently completed training for the Pharmacy First service and flu vaccination service. And she had completed declarations of competence and consultation skills for the services offered and had done the associated training. And she felt able to make professional decisions.

Team members had informal daily huddles to discuss any issues, tasks that needed prioritising and targets. The store manager explained that she regularly attended meeting with the area manager and other pharmacy managers in the area. She said that she passed on information from the meeting to the team. She said that during a recent meeting, the new list of medicines included in the New Medicine Service was discussed. Team members had yearly performance reviews. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were set for the NMS, the Pharmacy First service and blood pressure checks. The store manager said that the pharmacy usually met the targets. And the pharmacist said that she would not let the targets affect her professional judgement. The team said that the services were provided for the benefit of people using

the pharmacy.

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 bright, clean, and tidy throughout which 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.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users, and it was in the shop area. It was suitably equipped and well-screened. 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. There were separate hand washing facilities available.

At the start of the inspection there were some bags of dispensed medicines at the side of the medicines counter which were potentially accessible to people in the shop area. After this was pointed out to the team, the store manager used a mobile display unit to restrict access to this area and she contacted the maintenance team to arrange for a more permanent solution.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines. 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. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. 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. The pharmacy technician explained that the pharmacy produced large print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Pharmacist's information forms (PIF) were routinely used to ensure important information was available throughout the dispensing and checking processes. And a note was made on the patient's medication record (PMR) to prompt team members to ask relevant questions or pass to the pharmacist before the medicines were handed out. And once this was done it had to be marked as actioned on the PMR. 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. This made it easier the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted, and the expiry date recorded on the PIF. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacy technician said that team members checked CDs and fridge items with people when handing them out. 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 pharmacy technician said that people would be referred to their GP if they needed to be on the PPP and weren't on one. And the pharmacy dispensed these medicines in their original packaging.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office, the NHS and the MHRA. The store manager explained the action the pharmacy took in response to any alerts or recalls. And any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response. 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 highlighted. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements and denaturing kits were available for the safe

destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, 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.

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. Part-dispensed prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Team members said that people were sent a text message when their items were ready to collect. Uncollected prescriptions were checked weekly, and people were sent a text message reminder if they had not collected their items after around five weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that the pharmacy carried out assessments for people who had their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. But prescriptions for 'when required' medicines were not routinely requested. The pharmacy technician said that people contacted the pharmacy if they needed these medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. 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. Team members wore gloves when handling medicines that were placed in these packs.

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 counting loose tablets was 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. The pharmacy had access to up-to-date reference sources online. Team members said that the blood pressure monitors were 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. The otoscope was cleaned after each use and disposable tips were used.

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.