

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 107 Bear Road, Hanworth, FELTHAM,  
Middlesex, TW13 6SA

**Pharmacy reference:** 1034889

**Type of pharmacy:** Community

**Date of inspection:** 06/10/2022

## Pharmacy context

This is a community pharmacy in a local branch of Boots. It is in a small shopping precinct in the centre of the community alongside four other shops and businesses. The pharmacy provides a range of services including dispensing prescriptions and it supplies medicines in multi-compartment compliance packs for people living locally who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. The pharmacy also provides a range of other services, including a blood pressure measuring service and a flu vaccination service.

## 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
<b>1. Governance</b>	Standards met	1.1	Good practice	The pharmacy team is good at identifying where and how it can improve after it makes a mistake. It identifies repeated mistakes, and it finds ways to help its team members identify them, reflect on them and improve the safety and quality of their procedures.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages its risks well. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team keeps people's private information safe. And it knows how to protect the safety of vulnerable people.

### Inspector's evidence

The pharmacy had experienced an increase in work pressures during the pandemic. This was in part due to an increase in prescription and delivery demands but it was also because of occasional staff shortages. And so, the pharmacy had reduced its range of services so that it could manage its dispensing service safely and effectively. But in recent months since staffing levels and workload had stabilised it had increased the number of services again. The pharmacy had a system for recording its mistakes. It recorded them electronically and reviewed them monthly in its patient safety review meetings. The responsible pharmacist (RP) was the regular RP. She highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. She did this to help them to reflect and learn from their mistakes. The team recognised the importance of monitoring and reviewing near misses and errors so that the team could learn as much as possible from them. And so the pharmacy's records reflected what the team had learned and what could be done differently next time to prevent mistakes and promote continued improvement. While the team had not made many mistakes, several of the ones it had made were because the wrong quantity had been dispensed. And so, the RP had reinforced the need for team members to carry out a quantity check. And the team had reviewed its procedures for managing the dispensing and storing of medicines in split packs. The RP had also reinforced the need for staff to conduct their own accuracy check after dispensing. They did this before transferring the dispensed item for a final accuracy check.

The pharmacy received a regular monthly newsletter from the superintendent. The newsletter highlighted areas of risk. And each month it identified common errors and ways to prevent them. It also provided educational information on a specific treatment or condition to keep staff knowledge up to date. The pharmacy had a set of standard operating procedures (SOPs) to follow. The team were in the process of implementing the latest versions of a selection of SOPs. But, in general the SOPs were up to date. And team members had read the SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the pharmacist when they needed her advice and expertise. The RP had placed her RP notice on display. The notice showed her name and registration number as required by law.

The pharmacy had kept measures in place to keep people safe from the transfer of infections. It had screens at its medicines counter. And it had hand sanitiser for the team and people to use. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points daily.

People could give feedback on the quality of the pharmacy's services. Each till receipt had information on the back on how people could report their experience of the service they had received at the pharmacy. And the pharmacy had cards available for people to pick up at the counter. The cards had similar information to that on the till receipts. People could also give feedback directly to team members. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints

procedure online. But in general, customer concerns were dealt with at the time by the pharmacist or by the store manager as appropriate. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. The pharmacy had received a number of customer concerns about medicines shortages, over which the team had no control. But to make sure that people did not go without their medicines team members spoke regularly to prescribers to arrange alternatives for them.

The pharmacy kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record, its private prescription records and its records for emergency supplies. It also had a CD destruction register for patient-returned medicines which was up to date. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They regularly updated their training on GDPR. And they also completed an annual e-learning training module. Confidential paper waste was discarded into separate blue waste bags. And it was collected periodically to be destroyed appropriately. People's personal information, including their prescription details, were kept out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online. And they had recently contacted the local safeguarding team about someone they had concerns about.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

### Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The RP was a Boots employed pharmacist who had worked at the pharmacy for approximately six months. The pharmacist worked alongside a dispensing assistant (DA), the store manager who was also a dispensing assistant. And a medicines counter assistant (MCA). The DAs and MCA had all completed the Boots pharmacy adviser training which combines MCA and DA training. The store manager worked on the counter and in the dispensary when he was not attending to managerial tasks. He helped the dispensary team during the inspection. And he helped in the pharmacy when it was busy. Overall, team members were seen to work effectively with one another. The pharmacy had a small team who worked regularly together. The daily workload of prescriptions was in hand and customers were generally attended to promptly.

Team members could discuss their concerns with the pharmacist or store manager as appropriate. And the team could generally discuss concerns with line managers if necessary. And they felt supported in their work. They had regular reviews about their work performance. And they kept their knowledge up to date through regular online e-learning training modules. Each member of the team kept an electronic record of their training. And the inspector viewed a sample of training records during the inspection. Pharmacists could make their own professional decisions in the interest of people and did not feel under pressure to meet business or professional targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help reduce the risk of the spread of viral infections. And its workspace is tidy and organised.

### Inspector's evidence

The pharmacy had a consultation room and a small retail area with seating for waiting customers. The consultation room was close to the counter and dispensary. And it was locked when not in use. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. The opening at the counter also connected the retail space to the back shop area. With a prescription storage area in between. This provided easy access for staff retrieving prescriptions for people. The counter had limited space for storing medicines and so the pharmacy kept its pharmacy medicines in a locked cabinet on a wall in the retail space close to the counter. The team had a retractable tape barrier to put in front of the counter to prevent people from going behind the counter or into the dispensary. The back shop area had staff facilities, further shelving for storage and an exit door. The door was kept locked to prevent unauthorised access.

The pharmacy had a compact dispensary. It had an 'L' shaped workbench for dispensing and checking. The checking area overlooked the medicines counter so that the pharmacist could oversee it. The workbench had storage areas above and below. The dispensary also had a 'U' shaped arrangement of shelving on its back wall behind the workbench. Dispensed items and prescriptions were stored so that people's information was kept out of view. Overall the pharmacy was tidy and organised. But it's walls and floors were marked and scuffed in places which meant that it did not look as clean and professional as it could have.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that it supplies its services safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly.

### Inspector's evidence

The pharmacy had a push-button operated automatic door and step-free access. Its customer area was free of clutter and unnecessary obstacles. And it had a delivery service for people who could not visit the pharmacy. It could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy used an automated bar-coded dispensing system (Columbus). The system had been designed to improve dispensing accuracy. Team members described how the pharmacist should make additional checks for higher risk prescriptions such as for a child or for a high-risk medicine. The pharmacy also supplied medicines against private prescriptions, many of which came from its online prescribing service. The prescribing service used both medical and pharmacist independent prescribers.

The pharmacy provided a blood-pressure measuring service. It highlighted people's prescriptions to alert the pharmacist when someone may be eligible for the service. And it had referred several people for further checks and medical intervention. The pharmacy supplied medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. Each month team members checked and verified any changes to prescriptions. And they updated people's records. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people had the information they needed. The pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking high-risk medicines. The pharmacy also had leaflets and information booklets on a selection of these medicines including sodium valproate. While it did not have anyone in the at-risk group taking sodium valproate team members were aware of the precautions they would need to take, and counselling they would give, if it were prescribed for someone new. The pharmacy's flu service had been in demand. But the RP managed the service in with her everyday workload. And she kept records according to the flu vaccination patient group direction (PGD) requirements. The RP had access to adrenaline injections should she need to respond quickly to someone with anaphylaxis.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It stored its medicines appropriately and in their original containers. And the stock on its shelves was tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the

inspector was in date. Team members identified and highlighted short-dated stock. And they put any out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. And it had a new blood pressure monitor for its blood pressure measuring service. Its equipment was clean. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, if they needed them. The pharmacy had several computer terminals which had been placed in the consultation rooms and in the dispensary. Computers had password protection. Team members had their own smart cards. They generally used their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles.

### 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.