General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 138 The Centre, High Street, FELTHAM, Middlesex, TW13 4BS

Pharmacy reference: 1034892

Type of pharmacy: Community

Date of inspection: 04/07/2024

Pharmacy context

This is a community pharmacy in a shopping centre in Feltham. The pharmacy provides a range of services including dispensing prescriptions. And supplying medicines in multi-compartment compliance packs for people living at home who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including the NHS Pharmacy First service and a winter flu vaccination service.

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 has appropriate written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. And team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The team responds well to feedback.

Inspector's evidence

The pharmacy risk assessed its services. And it provided non-essential services when the workload allowed and when it had enough suitably trained staff available for support. The pharmacy had systems in place for recording its mistakes. The pharmacy manager, who was also a pharmacist, described how pharmacists highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. They did this to help prevent the same mistake from happening again. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it recognised that mistakes could occur between them. These included medicines such as such as amlodipine 10mg and amitriptyline 10mg. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. The team recorded its mistakes on its electronic system. And so, team members had to wait for a computer to be free to make the necessary record. The records seen did not show what team members had learned or what they would do differently next time. So that they could prevent the same or a similar mistake.

The pharmacy used a barcode checking system to help reduce picking errors. And so, it did not make many mistakes. But the majority of those it did make involved the incorrect quantity. Or an incorrect entry of data by a team member. The team reviewed its near miss records weekly. But it was agreed that if it had more details of what it had learned from its mistakes, it could monitor them more effectively. And provide team members with a better opportunity to learn. And it would allow them to identify steps in their dispensing procedures which would help avoid mistakes in future. And any other follow up actions for ongoing improvement. The pharmacy received regular bulletins from the company's professional standards team. The bulletins provided updates on current priorities for teams and educational information. And they also provided case studies to highlight the risks associated with high-risk medicines.

The pharmacy had a set of up-to-date SOPs to follow. The SOPs were available on the Boots 'hub' application which team members had on their smart phones. Team members had read the SOPs relevant to their roles. And they had completed a quiz for each one to assess their knowledge and understanding. The pharmacy assistant (PA) serving customers on the counter had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. The PAs working as dispensing assistants consulted the RP or the pharmacy manager when they needed their advice and expertise. They accessed, used and updated the pharmacy's electronic records competently. And they were seen to work through their allocated tasks methodically. The RP had placed her RP notice on display showing her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint with head office if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time, or through the company's online portal. People had often expressed their concern about medicines shortages. And so, the team worked closely with local surgeries to ensure that people did not go without essential medicines. And it arranged for alternatives when they received a prescription for an item that they could not get. For people on repeat medicines, team members often called the person to ask them how much of their medicine they had left. So that they could prioritise prescriptions appropriately. And suggest an alternative for their GPs to prescribe. So that they did not run out. People had previously complained about waiting times for prescriptions. Team members realised that waiting times had been affected when they had to wait to use the computer at the prescription reception desk to access people's details. And to find out about the progress of their prescriptions. And so, they requested an additional computer from head office. Since its installation waiting times had reduced. The manager had also asked for additional scanning devices so that staff did not have to wait too long for one to become available. This meant that scanning prescriptions in and out had become more efficient. Staff were observed handling people's queries well. And they helped each other when needed. The pharmacy had professional indemnity and public liability arrangements so it could provide appropriate insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to. This included its private prescription records, records for emergency supplies and its RP record. The pharmacy kept its controlled drugs (CD) register properly. And it kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. The pharmacy also had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. They discarded confidential paper waste into separate waste bags. And a licensed waste contractor collected the bags regularly for safe destruction. The pharmacy kept people's personal information, including their prescription details, out of public view. And it had a safeguarding policy. Team members had completed safeguarding training. And they understood their safeguarding responsibilities. And they reported any concerns to social services or a person's GP as appropriate. The team could access details for the relevant safeguarding authorities online. But it had not had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has put suitable measures in place to ensure it manages its workload safely and effectively. And its team members support one another. Team members are comfortable about providing feedback to one another so they can maintain the quality of the pharmacy's services. And they have the right skills and training for their roles.

Inspector's evidence

The responsible pharmacist (RP) was the regular RP. And she had worked at the pharmacy for several years. Other team members present included the pharmacy technician, and the three PAs. A fourth PA worked mainly on the counter and shop floor. But she was available to help in the dispensary if needed. The PA role provided the team member with dispensing assistant training and medicines counter assistant training. And so, they could work wherever they were most needed, either in the dispensary or at the counter. The pharmacy was generally on top of its workload. And they worked hard to keep on top of their dispensing tasks. At the same time, it dealt promptly with people waiting for prescriptions or advice.

Staff described feeling supported in their work by their colleagues. And overall, they worked effectively with one another. The PA spoken with described having regular one-to-one meetings with the RP and the manager. She and the rest of the team felt able to raise concerns with their line managers. Team members discussed issues as they worked. And they described how they had got together to review the way in which they managed the prescription workflow. They did this to ensure that they could get people’s prescriptions ready for them more quickly when they came in to collect them. They also agreed to vary each team member’s tasks, sharing them to provide variety and maintain interest and concentration. The RP made day-to-day professional decisions in the interest of people. And while she felt the pressures of a busy workload, she did not feel under pressure to meet any business targets. The team had regular reviews about their work performance recently. And they discussed issues as they worked. And they kept their knowledge up to date through regular online e-learning training modules.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they provide an adequate amount of space for those services. The pharmacy is sufficiently clean and secure. The team keeps its workspace and storage areas appropriately tidy and organised.

Inspector's evidence

The pharmacy was in a retail park in the centre of Feltham. It had a retail space with a consultation room and a small seating area for people waiting. The pharmacy displayed its pharmacy medicines on the backwall behind its medicines counter. The dispensary extended alongside the counter. And its prescription reception area overlooked the shop floor, next to the counter. This allowed staff working there oversee the customer space. And so, they could see when people needed attention. And when their colleague on the counter might need assistance. The other part of worksurface was more out of view. And staff could work here with fewer interruptions. This provided a slightly quieter area for team members to work. The dispensary also had a small hatch here. Which provided a more discreet area away from people at the counter. The pharmacy team used the hatch to provide people with medicines such as methadone. And they could supervise them with more privacy.

The pharmacy generally had the workbench and storage space it needed for its workload. It had storage areas above and below its work benches. It also had a run of pull-out drawers and shelves for storing medicines and completed prescriptions for collection. The pharmacy stored its dispensed items and prescriptions so that it kept people’s information out of view. And it stored its medicines in a tidy, organised way. People could not view the pharmacy’s dispensing benches from the customer area. And this helped the team to keep people’s prescription information confidential. The pharmacy had a part-time cleaner who cleaned floors, work surfaces and staff areas regularly. The rest of the team cleaned the pharmacy's work surfaces and contact points regularly. And in general, it kept the premises tidy and organised. Staff worked steadily to put stock away and store prescription orders appropriately. The consultation room was near the dispensary. People outside the consultation room could not hear conversations taking place inside it. And the team locked it after use to prevent unauthorised access. The pharmacy had staff facilities upstairs. And a large storeroom. It had a fire door to the back.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that its services are supplied safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, 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 it gives people the information they need so they can take their medicines properly.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access and a button operated automatic door. And the team kept the retail area relatively free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it also ordered some people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help avoid errors. It also had a barcoded prescription retrieval system. So, by scanning the code, staff could access the correct prescription efficiently. And they could also refer to the original prescription which remained attached.

Pharmacists gave people advice on a range of matters. They gave advice to anyone taking higher-risk medicines. And they attached laminated warning cards to bags of dispensed high-risk medicines. They did this to remind team members to alert the pharmacist when handing out one of these medicines to people. So that they could counsel them properly. And give them the advice they needed about how to take their medicines safely. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This did not include people in the at-risk group. But team members described the counselling they would give when supplying the medicine to ensure that at-risk people taking it were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets each time. And the team was aware of the rules around the packaging of each supply.

The pharmacy offered the NHS pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a GP. The pharmacy had received requests directly from people. And from its local GP surgeries. Its most common requests were from people seeking treatment for sore throats and uncomplicated urinary tract infections (UTIs). Pharmacists had the appropriate protocols to follow. And they kept the necessary records for each supply. It was clear that they understood the limitations of the service and when to refer people to an alternative health professional.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was mostly tidy and organised. But it had two plain, white cartons of commonly prescribed medicines which it had dispensed last year. And it had put them back into stock after people had not collected them. The medicine packs had been marked with a batch number and expiry date, but these details had been removed from the strips inside. The inspector and pharmacy manager discussed this and agreed that stock stored this way should be removed if team members have not had the confidence to dispense

them again after a short period of time. The team agreed that all medicines should be stored in the manufacturer's original packaging where possible. The pharmacy date-checked its stocks regularly. And it kept records to help the team manage the process effectively. The team also conducted an expiry date check as part of its dispensing process. The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside each of its fridges was kept 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 its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The pharmacy had several computer terminals which had been placed in the consultation room and the dispensary. Computers were password protected to prevent unauthorised access. And team members had their own smart cards to maintain an accurate audit trail when accessing people's records. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.