General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 716 Field End Road, RUISLIP, Middlesex, HA4 0QP

Pharmacy reference: 1035088

Type of pharmacy: Community

Date of inspection: 01/02/2023

Pharmacy context

This is a community pharmacy in a local branch of Boots in Ruislip. The pharmacy provides a range of services including dispensing private and NHS prescriptions. And it has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a flu vaccination service. It supplies medicines for its substance misuse service. And it offers a blood pressure testing 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
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.

Inspector's evidence

The pharmacy used an electronic system for recording its 'near miss' mistakes and errors. And it reviewed its records each month in its patient safety reviews. But the system was relatively new, and the team had not yet fully used it. So, it had not entered all its recent near misses. And the sample of records available did not include much detail. But the pharmacist described how she and her pharmacist colleagues highlighted and discussed 'near misses' and errors with staff as soon as they discovered them. This enabled team members to reflect and learn. The inspector and pharmacist discussed the importance of recording what the team had learned from its mistakes and any actions arising from them. And they agreed that near misses should prompt team members to consider what had gone wrong and identify what they could do differently next time. But while the team had not kept full records of its near misses it was clear that it had taken steps to reduce the risk of repeating them. Staff described how they checked their own dispensing before passing to the pharmacist for a final accuracy check. And they had taken steps to ensure that they marked split packs of medicines clearly, so they could identify them easily. And people got the quantity they were expecting. Staff had also displayed a copy of the standard operating procedure (SOP) for handing out completed prescriptions on the wall in front of the main dispensing and checking bench. They had done this to remind themselves of the steps to follow when handing out a prescription. And to prevent a handout error. 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 selected treatment or condition.

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 had received an updated SOP for the New Medicines Service. And team members were in the process of reading it. They appeared to understand their roles and responsibilities and they consulted one of the pharmacists when they needed their advice and expertise. The RP had placed her RP notice on display where people could see it. The notice showed her name and registration number as required by law.

The pharmacy invited people to give feedback on the quality of its services. Each till receipt had information on the back for people to report their experience at the pharmacy. People also gave feedback directly to team members, or they could pick up a customer comment card at the counter. The pharmacy team knew how to 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 the pharmacy usually dealt with any concerns at the time. Recently, people had told the team that they preferred to have a regular Boots pharmacist on duty because it made them more comfortable about asking questions and getting advice. So, pharmacists from other branches often supported the team to help manage the pharmacy and provide consistency. This would continue until the pharmacy had a new pharmacist manager. Other recent customer comments indicated that many people were unhappy if the pharmacy did not have their medicines in stock. Or when there were manufacturers' delays. And so, team members spent time consulting with other local pharmacies so that people did not go without their medicines. And they tried to keep people's preferred make of medicine in stock. 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 generally kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record, its emergency supply records and its private prescription records. And it 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. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. 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 appropriate safeguarding training. And they understood their safeguarding responsibilities. And they reported any concerns to social services, the police or a person's GP as appropriate. The team accessed details for the relevant authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has put 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 inspector conducted the inspection during the pharmacy’s usual trading hours. The pharmacy did not currently have a regular responsible pharmacist (RP). And so, locums and Boots relief pharmacists provided its pharmacist cover. In the absence of a regular RP, a pharmacist manager from another store provided management support, assisted by other Boots store-based pharmacist colleagues. The RP on the day of the inspection was a Boots relief pharmacist who had worked there before. And a pharmacist from another store was there to provide training. But she also supported the team with their tasks. And with the inspection. Other team members present included a technician, a dispenser, and a trainee pharmacy adviser (PA). The PA role provided the team member with dispensing assistant training and medicines counter assistant training.

The pharmacy was generally on top of its workload. An IT issue the day before had caused a set-back. And so, it had a backlog of prescriptions waiting to be dispensed and checked. But the team expected to catch up by the end of the week. The team worked hard to keep on top of its dispensing tasks. At the same time, it dealt with people waiting for prescriptions or advice. But staff described feeling supported in their work by their colleagues. And overall, they were worked effectively with one another. They had raised concerns about staff shortages and workload to their line managers. Particularly as they had seen a rise in prescriptions following the closure of two pharmacies in the local area. This included a small branch of Boots. And their discussions with line managers had, in part, led to the support it was now receiving from other branches. Team members discussed issues as they worked. And the pharmacist made day-to-day professional decisions in the interest of people. And while she felt the pressures of a busy prescription service, she did not feel under pressure to meet any business targets. The team had not had any reviews about their work performance recently. But they discussed issues as they worked. When time allowed, 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 on a small parade of shops and local businesses. It had a retail space with a consultation room and a small seating area for people waiting. And it had screens on top of its counter to help prevent the transfer of infections. The pharmacy displayed its pharmacy medicines on the backwall behind its medicines counter. The dispensary extended to the rear of the counter. It had an ‘L’ shaped area of work surface. And one part of this work surface allowed staff working there to oversee the retail space and the counter. And so, they could see when people needed attention. The other part of work surface was more out of view. And staff could work here with fewer interruptions. The dispensary had a further short run of work surface to the rear which provided a quieter area for team members to work. The team prepared it multi-compartment compliance packs here.

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 team cleaned the pharmacy's work surfaces and contact points daily. And in general, it kept the premises tidy and organised. During the inspection dispensary floors were cluttered with stock deliveries and prescription orders. But staff worked steadily to put stock away and store prescription orders appropriately. The consultation room was close to 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 a staff area, staff facilities, a small storeroom, and a fire door to the back.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures help ensure that it supplies its services safely. 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 and protect people’s health and wellbeing. The pharmacy team supplies medicines with information that people need. So, they can take their medicines properly and safely.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access and an 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.

The pharmacy provided medicines in multi-compartment compliance packs for people who needed them. The pharmacy’s labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And it labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. The pharmacy organised its compliance pack service in accordance with a rolling four-week cycle. And it had a system for adjusting its supplies for any mid-cycle prescription changes. And any changes made after someone had been discharged from hospital.

Pharmacists gave people advice on a range of matters. The RP explained how she gave the appropriate advice to anyone taking higher-risk medicines. She described how she counselled people taking warfarin labelled with the directions ‘as directed’ to ensure they understood how they should take them. And to ensure that they had an up-to-date international normalised ratio (INR) measurement. This was to establish that their blood clotting time was within the correct range on their prescribed dose. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This did not include people in the at-risk group. Team members described the counselling they gave when supplying the medicine to ensure that 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.

The pharmacy also offered a flu vaccination service. It had up to date PGDs and service specifications for both the private and NHS flu service. In general, the RP briefed the person receiving the vaccination appropriately, and asked for their consent. The RP sanitised or washed her hands before and after each consultation. And she discarded used vaccines safely into a sharps bin. The RP kept records of the consultation for each vaccination. This included details of the product administered. The pharmacy had procedures and equipment for managing an anaphylactic response to vaccinations. And it had reminder notices on the wall which showed the procedures it should follow.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately. And stock on the shelves was generally tidy and organised with medicines stored in the manufacturer's original packaging. 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. It identified and highlighted its short-dated stock. And it put its out-of-date and patient returned medicines into dedicated waste containers. The team stored 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 to drug recalls and safety alerts. The team had not had any stock affected by recent recalls. But it agreed that it was important to check its emails every day. This would ensure a prompt response to any emails about recalls it might be affected by.

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 confidential 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 team had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had three computer terminals. One in the consultation room and two in the dispensary. Computers had password protection to prevent unauthorised access. The pharmacy had cordless telephones. This was to enable the team to hold private conversations with people without others overhearing.

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.