General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit G34, The Bentalls Centre, Wood Street, KINGSTON UPON THAMES, Surrey, KT1 1TR

Pharmacy reference: 1036635

Type of pharmacy: Community

Date of inspection: 25/10/2023

Pharmacy context

This is a medium-sized branch of Boots inside a busy shopping mall in the centre of Kingston-upon-Thames. It is accredited as a Healthy Living Pharmacy (HLP). Its main activity is dispensing people's prescriptions. It sells over-the-counter medicines and provides health advice. And also offers flu vaccinations during the autumn and winter seasons.

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	1.1	Good practice	Members of the pharmacy team have to successfully complete a quiz for each SOP before they are signed off as competent to carry out the associated tasks. The team holds regular meetings to discuss their mistakes so that they can all learn from them. There is also an easily accessible emergency bag with a business continuity plan and contact list inside.
		1.8	Good practice	There is a clear culture of safeguarding with examples where concerns have been identified and reported appropriately. This is particularly relevant considering the volume of EHC consultations carried out by the pharmacy
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	4.1	Good practice	The pharmacy has focused on developing its EHC service in response to an identified need in the area. This has, over the years, been noted as contributing to a significant reduction in unwanted pregnancies locally
		4.3	Good practice	The pharmacy systematically checks its stock to ensure it is fit for purpose. It keeps records of those checks together with audit trails to show who was involved in each step dispensing those medicines, from the initial prescription download to the final handout. There is also an audit trail to show who has possession of the CD keys and when they are locked away.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy provides its team members with clear written instructions on how to carry out their tasks safely and effectively. It is good at ensuring they understand how to carry out those tasks. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy regularly reviews the mistakes its team members make and takes appropriate action to reduce the chances of similar mistakes happening again. It keeps all the records that it should, making sure they are easily accessible. Its team members have a good understanding of their role in helping protect vulnerable people. The pharmacy manages and protects confidential information well and tells people how their private information will be used.

Inspector's evidence

There were Standard Operating Procedures (SOPs) in place to underpin all professional standards. They were all online and available to each team member on their personal device or computer. The manager could also see each individual team member's progress with signing off the SOPs. There was a quiz for each SOP, which had to be successfully completed before the individual team member would be signed off to carry out the task(s) associated with each SOP. The manager's report indicated that every member of the team was up to date with their SOPs. The SOPs were regularly reviewed and updated centrally, and everyone had completed the most up-to-date versions. Several had been updated in June and July, and the most recent was a pharmacy leadership module in Oct. Staff roles and responsibilities were linked to the SOPs that had been signed off, so that they only carried out tasks they were competent to do. Those team members questioned were all clear on the correct procedures to follow.

Errors and near misses were seen to be regularly recorded on two online platforms. Near misses, which were errors that had been identified and corrected whilst still within the pharmacy, were recorded on the Datix platform. Errors which had been identified after the medicine, or service, had been provided to people, were recorded on the PIERS platform for onward reporting centrally to the NHS 'learn from patient safety events' (LFPSE) service. The entries included details of who had been involved in the mistake, what had been learned as a result and any action taken to reduce the chance of it happening again. There was a 'patient safety champion,' who reviewed them with everyone at regular monthly meetings. They also completed a 'Patient Safety Review' (PSR) every month for head office. Copies of these reviews were available for all staff to read. The responsible pharmacist (RP) explained that the new Columbus patient medication record (PMR) system had resulted in a reduction in selection errors, and that the most frequent type of errors involved either incorrect quantities or an unrecognised barcode. One of the entries examined on the system involved a new product which neither the PMR system nor the error reporting system recognised. All such items were now flagged to the pharmacist on the printed pharmacist information form (PIF) so that he would know that they had not been successfully scanned and therefore needed an extra check. The 'select and speak' signs had been left adjacent to the 'look-alike, sound-alike' medicines (LASAs) as an additional prompt to check when picking those items, even though the 'select and speak' process had been superseded by the introduction of the barcode scanning.

There was a business continuity plan, together with an emergency contact list and equipment in a blue bag in the dispensary so that staff could easily find it in an emergency. People working in the pharmacy were able to clearly explain what they do, what they were responsible for and when they might seek

help. The paper RP record was seen to be complete and up to date. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist notice was correct and clearly displayed for people to see.

The pharmacy seeks people's views either directly in person or through its website. The RP stated that the feedback they received was positive overall, and that they acted upon it where possible. One example being the inclusion of more seating when the pharmacy had been refitted. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display. It included contact details for the company's head office, Patient Advice and Liaison Service (PALS) and the Independent Complaint Advocacy Service. A current certificate of professional indemnity and public liability insurance was held electronically on the company's intranet.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and all those inspected were complete with all the necessary details correctly recorded. Emergency supply records were also maintained electronically, complete with details of the emergency and a reason for supply. The RP explained how they recorded details of the potential impact upon the person requesting the supply as part of their reasoning. Some requests were made directly by people and some others came via the community pharmacist consultation (CPCS) service.

The controlled drug (CD) register was seen to be correctly maintained, with all wholesaler addresses written in full. Running balances were checked weekly, every Sunday, in accordance with the SOP. Stock balances of two random samples were checked and found to be correct. Amendments to the records were asterisked with a signed and dated footnote to identify who had made the amendment, and the reason for doing so. The RP was aware of the need to ensure that the person making the amendment could be easily identified. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. There were no Records of unlicensed 'specials' as the pharmacy hadn't needed to obtain any for a long time.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. Confidential waste was kept separate from general waste and shredded offsite. There was a privacy notice on display for people to see. Completed prescriptions awaiting collection were stored on labelled shelving with opaque fronts, so they were not visible to those waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies, including those for children and young adults, were on a noticeboard in the dispensary so that staff could easily find them. The RP had been trained to level three in safeguarding, and all other staff members had undergone either level two or level one Boots e-learning. Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist. All staff were dementia friends.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely and effectively. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They work well together and can make suggestions to improve safety where appropriate.

Inspector's evidence

There were two pharmacy advisors (one part-time and one full-time), one healthcare advisor, the manager (who was also a pharmacy advisor), a trainee pharmacist and the RP, on duty during the inspection. The RP stated that they were a very good team and that they all supported one another. He could also call upon the manager to help if necessary. Everyone was carrying out their tasks calmly and people appeared to be served in good time. All staff wore badges showing their names and role.

Certificates to confirm staff qualifications were available online to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. The manager demonstrated how they could track the progress of each staff member's training through a report available on their phone. Those staff questioned were able to demonstrate an awareness of potential medicines abuse and could identify people making repeat purchases. All members of staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines.

The trainee pharmacist had started the foundation year during the summer and had recently completed the 13-week assessment. Both the trainee and the supervising pharmacist (the RP) expressed satisfaction with the progress to date. The trainee described the variety of training opportunities he had been given so far. He was in regular contact with other foundation year trainees so that they could share their experiences and help support each other. He felt that there was a lot to get through but acknowledged that it could be planned out across the whole year so that by the time of the 39-week assessment he could then focus on the registration assessment.

The RP was comfortable with making professional decisions and was not pressurised to compromise his professional judgement. There were targets in place, but they were applied sensibly. Team members were involved in open discussions about their mistakes and learning from them. Team members said that they could raise concerns and that there was a whistleblowing policy available for them if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The team keeps them very clean and tidy, presenting a suitably professional image. The premises include a private room which the team uses for some of its services and for private conversations.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance from the shopping centre. The premises were accessible to people with pushchairs or those with mobility issues, as there was plenty of space. The pharmacy premises were notably clean, tidy and in a good state of repair. There was a medium-sized dispensary which was well organised with separate assembly and checking areas. The workstations were kept very tidy and free of clutter.

There was a notice board and leaflet display with posters highlighting current local health priorities. There was a consultation room for confidential conversations, consultations and the provision of services. There was no confidential information on view inside the consultation room. The door was kept locked when the room was not in use. There was a small sink with hot and cold running water. There was also a portable clear screen available for use if people were concerned about the transmission of airborne viruses.

The sink in the dispensary was clean with no limescale. There was hot and cold running water and handwash available. Room temperatures were appropriately maintained by combined heating and air-conditioning units, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely.

Inspector's evidence

There was a range of leaflets providing general health information and the services available from the pharmacy. The pharmacy provided a limited range of additional services as its main focus was dispensing NHS prescriptions. Members of the pharmacy team make use of an online translation service so they can communicate effectively with people whose first language is not English. The RP described an example where this helped ensure the person understood how to take their medicines.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting LASAs on shelf with 'select & speak' labels, complementing the barcode scanning which helped to prevent errors when the medicines were scanned as they were selected. The team printed and attached PIFs to prescription tokens to communicate messages about the person's medicines to the pharmacist. These were used to highlight new medicines, changes to their medicines, any allergies and whether the patient was eligible for further services or other interventions. The form also had a blank box to write any further information that the dispenser thought the pharmacist should be aware of, for example if the product had not been successfully scanned. There was also a selection of laminated prompt cards for specific types of prescription, for example those for babies and young children, or those for high-risk medicines such as warfarin. They prompted staff to check key safety information with the person collecting the prescription. They used baskets to keep individual prescriptions separate, and prescription labels were initialled to show who had dispensed and checked them. The system also endorsed the prescription tokens with prompts for the staff to sign showing who had labelled, clinically checked, assembled and completed the final check. Staff initialled the bag label on the finished prescriptions to complete the audit trail, signifying who had filled the bag and checked that it was complete and correctly labelled. The manager explained how they added an extra signature on the bag itself to indicate who had filed the completed prescription in the retrieval system. There was a separate signature to show who then handed the bag out to the patient. All of this helped to identify who had been involved at each stage in the process if any query arose after the prescription had been handed out. The RP and manager also confirmed that all their prescriptions were assembled onsite as they did not use any of the company's dispensing support pharmacy (DSP) hubs. Owings tickets were in use when medicines could not be supplied in their entirety. The prescription was completed as soon as the missing item was back in stock.

Prescriptions for CDs or fridge lines in retrieval awaiting collection were highlighted with laminated prompt cards so that staff would know there were items to be collected from the fridge or CD cupboard. The pharmacist demonstrated the process to ensure that controlled drug prescriptions weren't handed out after their 28-day expiry. There were prompt stickers on the bags which included the date after which the prescription could not be handed out. The dates on Schedules 2, 3 and 4 CD

prescriptions were all highlighted with their expiry date. The prescription retrieval shelves were cleared every week of anything over four weeks old. One of the dispensary team would send a reminder text to the person concerned before the medication was returned to stock and the EPS prescription returned to the NHS spine.

Staff were aware of the risks involved in dispensing valproates to people who could become pregnant, but the pharmacy currently had nobody in the at-risk group being prescribed any valproates. The RP described how anyone in the at-risk group would be counselled and provided with leaflets and cards highlighting the importance of having effective contraception. And that any such interventions would be recorded on the PMR system.

People taking warfarin were asked if they knew their current dosage, and their INR results were recorded on the PMR system. People taking methotrexate and lithium were also asked about blood tests. There were laminated prompt cards to go with the PIF to ensure that staff checked, and the key points were listed on the reverse to remind them.

The pharmacy was currently providing a seasonal influenza vaccination service. There were signed patient group directions (PGDs) in place, valid until the end of March 2024. There were also declarations of competence and associated training records for the pharmacists providing the service. There were signed PGDs in place for the supply of levonorgestrel and ulipristal for the NHS funded EHC supply service. They were both next due for review in November 2025 and valid until May 2026. The uptake of the EHC service provided by this pharmacy had grown significantly over the past few years. To the extent that they were now providing the service to as many people each week as they had been originally every six months. The RP explained that pre-pandemic, he regularly attended meetings with the service's commissioners, during which they reported that unwanted pregnancy rates in the borough had significantly reduced as a direct result of the service availability.

The pharmacy received some private prescriptions direct from the company's online doctor service. These used a recognised secure digital signature so that the prescription could only be dispensed once. The private prescriptions issued through this service were appropriately recorded using the private prescription facility on the PMR system.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance. Unlicensed 'specials' would be obtained from Alliance Specials or BCM if necessary. Routine date checks were seen to be in place, and record sheets were seen for each quarter. Items approaching their expiry date were recorded on monthly sheets, with records present for items due to expire up to three months ahead.

Fridge temperatures were recorded daily, and all seen to be within the required temperature range. The RP explained how they would note any variation from this and recheck the temperature more frequently until it was back within the normal range. Medicines would be safely disposed of if necessary. Pharmacy-only medicines were displayed behind the medicines counter.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. People returning sharps were signposted to the Boots branch in the nearby Kingston hospital. This was generally quicker and more convenient for people than referring them to the local council. There was a tray containing protective gloves and goggles, together with a laminated instruction sheet to help staff safely sort through any returned medicines before placing them in the designated waste container. This was collected by an approved waste contractor.

The pharmacy received drug alerts and recalls from the MHRA via 'my calendar' on 'Boots Live', printed

copies of which were kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable facilities for the services it provides, and it makes sure that they are properly maintained. It also ensures that people’s private information is kept safe and secure.

Inspector's evidence

The pharmacy equipment and facilities were seen to be appropriate for the services provided. The consultation room was clean and tidy. There was a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics, which was clearly labelled. There was one medicines fridge, and one CD cabinet. The pharmacy had up-to-date copies of the BNF and BNF for children, as well as internet access which they used as an additional reference source.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen in use with no sharing of passwords.

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.