General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 813 High Road, Leytonstone, LONDON, E11 1HQ

**Pharmacy reference:** 1040134

**Type of pharmacy:** Community

**Date of inspection:** 19/03/2024

## Pharmacy context

This is a medium-sized branch of Boots on the High Road running through Leytonstone in East London. It dispenses people's prescriptions, sells over-the-counter medicines and provides health advice. It offers consultations and some medicines through the Pharmacy First service. And also offers flu vaccinations during the autumn and winter seasons.

## 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 | 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, which it documents, to discuss their mistakes so that they can all learn from them. |
| | | 1.2 | Good practice | Records of near misses and errors are regularly reviewed, with records being kept to show what has been learned. They are shared with their area manager and head office who take action if required. They also carry out regular and frequent checks on their work to make sure they are following the correct procedures. |
| **2. Staff** | Standards met | 2.2 | Good practice | The pharmacy gives its team members protected time at work so they can complete their training and keep themselves up to date. The training included easily accessible video animations to help bring the training to life. More experienced team members help and support those still learning. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | 4.2 | Good practice | The pharmacist uses her professional judgement when people fall outside the scope of some of the pharmacy's services, communicating effectively with their GPs so that they still receive the treatment they require. This results in positive health outcomes without the need for people to make further appointments to see their GP. They can also show that their new process has improved patient safety, ensuring that everyone is confident in following the new process before removing any extra checks. |
| **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. Its team members understand 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

The pharmacy had up-to-date Standard Operating Procedures (SOPs) in place to help its team members carry out their tasks and 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 could track everyone's progress and make sure they all stayed up to date with their SOPs. The SOPs were regularly reviewed and updated centrally. The most recent SOPs related to the recently introduced Pharmacy First service. 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. These mistakes were also escalated to their Area Manager for them to review and take action if necessary. 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 RP explained that the newly introduced Advanced Due Date Dispensing (ADDD) process had significantly reduced the number of mistakes. The pharmacy completed regular clinical audits as part of the pharmacy quality scheme (PQS), an anticoagulant review, antibiotic stewardship review and one on urinary tract infections. There was also a regular overall store audit to make sure they were following all their internal processes. The manager carried out a weekly clinical governance check, usually on Saturdays.

The pharmacy had a business continuity plan, together with an emergency contact list, so staff would know who to contact 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. 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 available online.

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. Those records of unlicensed 'specials' examined were complete and in order.

The controlled drug (CD) register was seen to be correctly maintained, with all wholesaler addresses written in full. Running balances were checked weekly, usually on a Saturday, 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, so also included their GPhC registration number. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed.

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 out of sight of people 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 available in the dispensary so that staff could easily find them. The RP had been trained to level two in safeguarding, and all other staff members had been trained to level one on e-learning for health (e-LFH). 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 a well-led team with enough people 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 was a trainee technician, one dispensing assistant covering the counter, one medicines counter assistant (MCA) dealing with a delivery and the RP on duty during the inspection. They were working well together, supporting each other with their tasks if required. There was a mix of full-time and part-time staff who could cover any unplanned absences. They were well-supported by the pharmacist and the trainee technician, who clearly worked very well together. The RP explained how they undertook a review of their staffing profile at least once a year.

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 RP demonstrated how the training modules included animations to help illustrate how key points related to situations they may encounter in their day-to-day work. They also described how they could track the progress of each team member's training through a report available on their phone. The trainee technician explained how she intended starting an accuracy checking course once she had completed her technician training so that she could be a registered accuracy checking technician (ACT). The dispensing assistant demonstrated some of the training modules she had completed and explained how she was provided with protected time at work to do it. 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 RP was comfortable with making professional decisions and was not pressurised to compromise her 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 environment for people to receive its services. The team keeps the pharmacy clean and tidy, despite the premises themselves looking dated and rather tired. The premises include a suitably secure and 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 from the street through two sets of double automatic doors. The premises were accessible to people with pushchairs or those with mobility issues, as there was plenty of space. The pharmacy premises were looking dated and showing their age. There was a small dispensary at the rear, which was full of baskets containing prescriptions awaiting a final accuracy check. But it was well organised with separate assembly and checking areas.

There was a notice board and leaflet display to highlight current local health priorities and the services available from the pharmacy. 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 desk, with two chairs and a password-protected laptop inside.

The sink in the dispensary was clean but did have some visible limescale. There was hot and cold running water and handwash available. Team members kept the worksurfaces and shelving clean and a cleaner regularly cleaned the floor. 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 easily 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 healthy living area with leaflets and posters highlighting health matters and some local providers. There were also signs in the window to tell people what services the pharmacy provided. The automatic doors made it easier for people using wheelchairs to enter the pharmacy. There was also plenty of space for them to move around the displays or to access the consultation room.

There were controls in place to help minimise errors, such as using baskets for each prescription so that their contents were kept separate from other prescriptions. Dispensing labels included ‘dispensed by’ and ‘checked by’ boxes to indicate who had carried out those tasks. The pharmacy also annotated the prescription tokens to show who had carried out the clinical check on each prescription. Any points the pharmacist needed to be aware of were also printed on a label that was stuck to the token (this information label replaced what was formerly known as the ‘pharmacist information form’ or PIF). Owings slips were used when prescriptions couldn’t be supplied in full. The RP described how they contacted the prescriber to seek a suitable alternative if they couldn’t obtain the necessary medicines.

The pharmacy had recently introduced a new process for dispensing prescriptions. They initially triaged their morning prescription download, identifying those that might be urgently required such as antibiotics. They were dispensed first so that they would be ready for collection when people arrived for them. Most of the remainder were then labelled and assembled in accordance with their new Advance Due Date Dispensing (ADDD or A triple-D) process. The prescriptions were clinically checked, the data input into their PMR system and then checked for accuracy before the stock order was transmitted to their wholesaler. Once the stock was delivered, scanning the barcode on each item identified which prescription it related to and which storage location it should be placed in once labelled. Both the label’s barcode, and the pack’s barcode were scanned to ensure they matched. The prescription barcode was also scanned, again identifying the storage location where the items themselves had been placed. Once this was complete, the items were manually checked for accuracy before being bagged up ready for collection. The RP explained that they would continue with the manual check until she was satisfied that all team members involved in the process were confident that the process was working properly. Once they had manually checked the required number of items, and the team was ready, they would stop the manual checks and rely upon the barcode scanning. As indicated under principle one, the RP had already seen a significant reduction in the number of errors since introducing this new process.

The pharmacy delivered some medicines using a team of drivers it shared with other local branches of the company. All items to be delivered were clearly labelled as such and were entered on an online portal for the drivers to access through their hand-held terminal (also referred to as PODs). The drivers

ticked off each successful delivery and returned any failed deliveries back to the pharmacy. Fridge lines and CDs were highlighted so that the drivers could ensure they were kept either in the van's fridge or secure storage.

The pharmacy assembled some prescriptions in multi-compartment compliance packs for people who found it difficult to manage their medicines. They were assembled in the staffroom when it wasn't being used by anyone else, so there were no distractions. Some compliance packs were seen on shelving that was only screened off with heavyweight plastic curtains secured with Velcro. Upon questioning about this, the RP explained that this was only temporary storage, used if the team member had to stop assembling the packs when others needed to use the room. There was a lockable cabinet for completed packs. The pharmacy ordered prescriptions on people's behalf on a four-week cycle. Upon receipt they checked that they were as expected, with any discrepancies being followed up with the GP practice and their PMR updated accordingly. Patient information leaflets were provided and there was a brief description of each tablet or capsule inside the compliance pack. The RP added that most of the packs were assembled four weekly and then delivered.

The pharmacy dispensed 'blue scripts' for people who used drugs. The daily supplies for the full week were all assembled together and people collected several days' worth at a time. If they failed to turn up, then that day's supply was withheld from the remainder of the supply. People who failed to turn up for their medicines on three consecutive days were referred back to their key worker and no further supplies were made until a new prescription was provided. The RP discussed any individual missed collections with the service provider when they arranged the next cycle of prescriptions. Those entries seen on the 'blue script' and in the CD register were all in order.

Those team members questioned were aware of the risks involved when supplying valproates to people who could become pregnant. They would check whether people had long-term contraception in place as part of the pregnancy prevention programme (PPP) and knew to record these interventions on their PMR system. They also knew about the newer requirements to only supply them in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with their dispensing labels. They checked whether people taking other high-risk medicines such as lithium, warfarin or methotrexate were having the regular blood tests they needed. The pharmacy kept INR records for those taking warfarin.

The pharmacy administered flu vaccinations during the autumn and winter seasons. There were valid patient group directions (PGDs) in place as the legal mechanism for providing the service. They had been signed and dated by the pharmacists. The pharmacy kept the necessary records and had adrenaline ampoules available in case of an emergency.

The pharmacy provided the recently introduced Pharmacy First service, keeping records of each consultation on the PharmOutcomes online platform. The RP had a file containing a referral guide, and the clinical pathways for each of the seven conditions listed in the service. They kept this paper record in case they were unable to access the online system. The RP described the verification process they had to follow in order to securely access the system. They also described how they often received referrals for people who fell outside the scope of the service, but still tried to help them. Examples included adults being referred for possible ear infections when the service specification for that condition limited them to those between 12 months and 18 years of age. So rather than turning them away, the RP took them through the pathway and then provided their GP with the results of their assessment. In at least two cases, these interventions resulted in prescriptions for antibiotics being sent to the pharmacy to treat the person's condition without the need for a separate GP appointment.

The pharmacy obtained its stock from recognised pharmaceutical wholesalers. It stored its stock in the manufacturers' original containers. There was a date checking matrix on a 13-week cycle and some items of stock had been clearly marked with coloured stickers to show that they were approaching their expiry date. Fridge temperatures were checked and recorded every day, confirming that they were within the required temperature range.

The were two CD cabinets securely bolted to the wall in accordance with the regulations. The pharmacy had the necessary kits to denature and safely destroy CDs. Unwanted medicines returned by people were checked for CDs and sharps. CDs were recorded before being put in the CD cupboard ready for safe destruction. Although the pharmacy didn't have a purple-lidded bin designated for hazardous waste, the RP knew how to obtain one if necessary. Unwanted medicines were collected by an approved waste contractor.

The pharmacy received drug alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) to advise it of any recalls or other problems with medicines or medical devices. They also received alerts from the local health authority to warn them about any stolen or falsified prescriptions that may be circulating in the area. The pharmacy annotated each alert with any action taken and each team member initialled it to show that they had read it. They were then retained in a designated file.

## 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 had a set of crown-stamped glass measures, with separate ones clearly marked for use only when measuring liquid CDs. Although clean, there was visible limescale on the measures and the sink. There were counting triangles for counting loose tablets, with a separate one clearly marked for use only with methotrexate. They were all clean and free from visible tablet dust. The pharmacy used the BNF and BNF for children, and also had online access to other reference sources if required.

The consultation room was clean and tidy, with a small desk and two chairs. There was a blood pressure monitor and an otoscope which had been recently acquired for the Pharmacy First service. The anaphylaxis kit contained a box of adrenaline ampoules which were in date.

All the computers were password protected, including the laptop in the consultation room. No computer screens, or other sources of confidential information, were visible to people using the pharmacy. There were locked filing cabinets in the stockroom which were used for securely storing the pharmacy's confidential paperwork.

## 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. |