

Registered pharmacy inspection report

Pharmacy Name: Boots, 31-32 The Mall, The Stratford Centre,
LONDON, E15 1XD

Pharmacy reference: 1040191

Type of pharmacy: Community

Date of inspection: 01/07/2024

Pharmacy context

This pharmacy is in a shopping centre in East London. The pharmacy mainly dispenses NHS prescriptions. It provides the Pharmacy First and flu vaccine services. And it provides medication to residents in care homes.

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	1.2	Good practice	Pharmacy team members proactively identify trends and patterns in the mistakes they make. And they make changes to the way they work to improve the safety of their services.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team are supported to complete regular training. This helps them develop their skills and knowledge.
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 good systems in place to manage the risks associated with its services. And it keeps the records it needs to by law, so it can show that supplies are made safely and legally. Team members respond appropriately when mistakes happen during the dispensing process. People who use the pharmacy can provide feedback. And team members are provided with annual training about safeguarding to help ensure that incidents are dealt with appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy. They were user-friendly and were also available in an electronic format. All current members of the team had read the relevant procedures. The SOPs were reviewed annually by the superintendent pharmacist (SI) and annotated to reflect this. Responsibilities of team members were listed on individual SOPs.

The store manager, who was also a pharmacist, said that the pharmacy's head office sent a 'Professional Standards' newsletter every month. This highlighted any mistakes which had occurred at other branches, case studies, drug safety updates and changes to processes. The team felt that these newsletters helped keep them informed and up to date with changes.

Dispensing mistakes which were identified before the medicine was handed to a person, also known as near misses, were recorded electronically. The pharmacy had a designated 'patient safety champion' who reviewed the near miss record at the end of the month and carried out a patient safety review. Individual patient safety reviews were done for the walk-in dispensary and the care home dispensing unit, and this helped ensure that any action points were relevant to each unit. These reviews were formalised and distributed amongst the team members to make them aware of any trends and patterns. Medicine packs were scanned onto the dispensing software as part of the dispensing process and team members said that this helped reduce dispensing errors and mistakes. The team annotated the prescription with 'NB' or 'no barcode' if a medicine pack could not be scanned. This helped make sure that additional care was taken when checking the medicine. The team had recently introduced an additional step in the dispensing process to help reduce quantity errors. This involved circling or ticking the quantity on the medicine pack. The team had also separated medicines that looked or sounded alike. A list of look-alike and sound-alike medicines was displayed at the various workstations. A display board was fitted outside the care homes unit, and this was used to display recent patient safety reports, 'pharmacy focus' posters, pharmacy community news, and flow charts of processes.

Dispensing mistakes which reached people, also known as dispensing errors, were recorded electronically and reported to the pharmacy's head office. There had not been any for some time. They would also be reviewed as part of the monthly patient safety reviews. The pharmacy had implemented additional steps for dealing with stock shortages, including contacting the person's GP for an alternative and updating the person. A checklist was completed and attached to the prescription to maintain audit trails of action taken in response to the shortages. This helped reduce supply failures.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) sign was clearly displayed, and samples of the RP record were in order. Private prescription and emergency supply records were held electronically, and these were in order. The

pharmacy had not dispensed unlicensed medicines for some time. A sample of controlled drug (CD) registers was inspected, and these were seen to be well maintained. The physical stock of a CD was checked and matched the recorded balance. Balance audits were conducted on a weekly basis. CDs which had been returned by people were recorded in a separate book and destroyed in a timely manner.

Members of the team handed out cards referring people to an online feedback form. The contact details for the pharmacy's head office could also be found in the patient guides which were provided to people accessing services. Team members said that they made sure to acknowledge people as soon as they arrived and communicate realistic waiting times, to help reduce complaints about waiting times. The store manager said that they planned the day in advance, taking into consideration any annual or emergency leave, to help improve the workflow.

Team members completed the company's eLearning modules on information governance, the General Data Protection Regulation and code of conduct, which were renewed annually. A hatch was fitted at one end of the dispensary to allow for more privacy for people collecting their medicines. A consultation room was available for private conversations and services. Computers were password protected and access to the patient medication record (PMR) system was via individual smartcards. Confidential waste was stored in separate waste bags which were collected by head office. Prescriptions and medicines awaiting collection were not visible to members of the public.

All members of the team had completed the company's annual eLearning module on safeguarding vulnerable groups. Team members were aware of the 'safe place' and 'Ask for Ani' initiatives and posters were displayed near the waiting area to inform people. The contact details of the local safeguarding teams were displayed in the dispensary for the team to refer to should the need arise.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to help manage its workload. The team members are well supported in their development and in keeping their knowledge and skills up to date. And they feel comfortable about providing feedback or raising concerns.

Inspector's evidence

The pharmacy had two teams, one covering the walk-in dispensary and another covering the care homes unit. During the inspection, there were two pharmacists, the store manager (also a pharmacist), two qualified dispensers, a trainee dispenser and a trainee medicines counter assistant covering the walk-in pharmacy. The care homes unit was covered by four pharmacy technicians and seven dispensers. Trainee members of the team were enrolled onto suitable courses. Team members felt there was sufficient staffing for the services provided at the pharmacy. The store manager said that members of the team could be moved between units to help cover annual or emergency leave. They could also seek support from local branches or the pharmacy's area manager. Although this was a busy pharmacy, the team managed their workload well throughout the inspection.

Team members had access to a range of training material to help keep their skills and knowledge up to date, including online modules, newsletters, and pharmacy magazines. Team members working in the care homes unit were provided with protected study time during working hours. Those working in the walk-in dispensary said they completed their training at home as the dispensary was busy throughout the day, but they were provided with time back.

Team members were aware of the whistleblowing policy and said they felt comfortable raising concerns or giving feedback to the pharmacists and store manager. They felt supported in their development and said that the store manager was approachable and responsive to their needs. Team members said that targets set by the pharmacy's head office were reasonable.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is well maintained, secured, and provides an environment that is suitable for the services provided. There is a room where people can have private conversations with a team member.

Inspector's evidence

This was a large shop with a spacious retail area. Aisles in the retail area were wide which allowed for easier access for people in wheelchairs. The dispensary and medicines counter were located to the back of the shop. The medicines counter was fitted with a lowered countertop for people in wheelchairs. Fittings throughout the store were well maintained. The cleaning was done out once or twice a week by a cleaner. Some cleaning tasks were also done by the team. There was a sink available in the dispensary with hot and cold running water to allow for hand washing and preparation of medicines. Soap, paper towels, and hand sanitizing gel were available. There was sufficient lighting throughout the premises.

The spacious consultation room was clearly signposted. It was clean and organised, and the door was kept locked when the room was not in use. The room was fitted with a computer unit and hand washing facilities. There was ample storage and workbench space in the dispensary. There was a spacious stock room on the first floor. A separate room, located within the stock room, was used to dispense medicines for care homes. The room was fitted with shelves, workbenches, and a sink. It was kept clean and tidy. A room beside the care homes dispensing unit was used to store excess stock.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has a range of systems which allow for its services to be provided in a safe and organised manner. People taking higher-risk medicines are identified to ensure they are provided with the appropriate advice about their medicines. The pharmacy obtains its medicines from reputable sources and stores them properly.

Inspector's evidence

Access into the pharmacy was step free and via wide, automatic doors. There was ample space for people in wheelchairs. Posters were displayed throughout the pharmacy to promote services such as the new Pharmacy First service. There were several wipeable chairs in the waiting area for people wanting to wait for a service. Team members described verbally referring people to services that they were eligible for and signposting people to other service providers. The pharmacy had contacted or visited local GP services to promote the Pharmacy First service and this had helped improve referrals from GPs.

'Pharmacist information forms' (PIFs) were used to highlight any changes to a person's medicine, allergy status, or if a person was suitable for a particular service. These were now generated automatically through the dispensing system and attached to dispensed prescriptions. Prescriptions were also scanned on the system to confirm that they were supplied. This further helped minimise hand out errors. Dispensing audit trails were maintained to help identify who was involved in dispensing, checking, and handing out a prescription. Members of the team were observed confirming peoples' names and addresses before handing out dispensed medicines.

Higher-risk medicines were flagged with coloured laminates and electronic alert labels. The coloured laminates listed all the relevant checks the pharmacy staff should make before supplying the medicine. Team members said that they had been briefed about the valproate guidance and were aware of the need to provide this medicine in its original pack. They were able to describe the additional checks and advice they should be provide to people taking this medicine. The pharmacy's head office had sent information about the new government restrictions on use of Puberty Suppressing Hormones and this had been read by the team.

Prescriptions for Schedule 2, 3 and 4 CDs were marked with coloured stickers which were annotated with the expiry date of the prescription. This helped reduce the risk of supplying these medicines past the valid date on the prescription. Clear bags were used to store dispensed fridge items and CDs. This allowed for a third check with the person at collection. Dispensed instalments were kept in separate compartments for each person.

In-date signed Patient Group Directions were available for the Pharmacy First service. Guidance and flow charts were easily accessible for the team. Support that the pharmacy had provided via the service ranged from advice only, over the counter medicines, or prescription-only medicines. The pharmacists described signposting people to their GP in certain cases, for example, recurrent infections.

The walk-in pharmacy had introduced 'assisted due date dispensing' to manage electronic walk-in prescriptions. This involved a pharmacist carrying out an initial clinical check of the prescription which

was then processed and checked by a dispenser. Once prescriptions were received, they were printed out and scanned onto the dispensing system which then automatically ordered the stock. Stock ordered via this process was received in a separate box to other orders. The system highlighted if additional checks were required by the pharmacist, for example, if a new item was prescribed. The pharmacist signed the prescription to confirm that they had conducted a clinical check. The dispenser then selected the stock and scanned the medicine pack and dispensing label. A final check was also conducted by the dispenser. Team members said that this system had helped improve the workflow and free up the pharmacists to provide other services. The pharmacy had seen a drop in dispensing mistakes since implementing the system in January 2024.

The care homes unit provided medication in original packs to over 40 care homes, ranging in size from four bed to 30 beds. Care homes were arranged over four weekly cycles. A 'progress log' was used to keep clear audit trails of when care homes were due their medicines, when their prescriptions had been received and processed, and when their medicines had been delivered. Prescription ordering was managed by care home staff, but the pharmacy sent a report of missing items or prescriptions if it identified any. Once prescriptions were received, the pharmacy generated Medication Administration Charts. The prescriptions were then clinically checked by the pharmacist before the stock was ordered and picked. A final check of the medicines was conducted by the pharmacists. Care homes were visited regularly by the pharmacy's care homes manager. Staff at the care homes had opportunities to ask questions and seek additional training on medicines management. Any communications between the pharmacy and care home staff were documented and retained in individual care home files.

Stock was obtained from reputable wholesalers and was stored tidily on the shelves. Expiry date checks were conducted regularly, and clear records were maintained to confirm this. Medicine with short expiry dates were highlighted with a coloured sticker. The fridge temperatures were monitored daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received electronically, actioned and documented.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it maintains them well.

Inspector's evidence

There were three pharmaceutical fridges which were clean and suitable for the storage of medicines. Several clean, glass measures were available at the pharmacy, including separate measures for certain liquid medicines. The pharmacy had tablet and capsule counters, with a separately marked counting triangle used for cytotoxic medicines. The blood pressure monitor and odometer were new and team members said this would be serviced or replaced annually. A resuscitation mask, pulse oximeter, and several in-date adrenaline packs were kept in the consultation room in case of an emergency. Waste medicine bins and destruction kits were available to dispose of waste medicine and CDs respectively. These were stored securely.

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.