General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 60 Gracechurch Street, LONDON, EC3V 0HR

Pharmacy reference: 1040270

Type of pharmacy: Community

Date of inspection: 24/04/2023

Pharmacy context

This pharmacy is situated in the City of London. As well as dispensing NHS prescriptions the pharmacy provides a number of private services including vaccinations for conditions such as chicken pox. The pharmacy is also due to launch a travel vaccination service. It also provides the New Medicine Service and Community Pharmacist Consultation 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	1.2	Good practice	The pharmacy is good at recording and reviewing mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors it. This helps team members keep their knowledge and skills up to date.
		2.4	Good practice	The pharmacy has a culture of shared learning and continual personal development. It gives its team members regular feedback. And team members doing an accredited course have a tutor who helps support them.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy provides a range of services and takes steps to make sure people can use them.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is good at recording and regularly reviewing any mistakes that happen during the dispensing process. And it uses this information to help minimise any future risks and help make its services safer. It identifies and manages the risks associated with its services to help provide them safely. And team members understand their role in protecting vulnerable people. The pharmacy regularly seeks feedback from people who use the pharmacy. And it keeps its records up to date and in line with requirements.

Inspector's evidence

Standard operating procedures (SOPs) were available and were up to date. Most SOPs were available digitally. Team members were required to read SOPs via their individual training profile. Hard copies of SOPs were also available. All team members had completed the SOP training required for their roles. The store manager was able to check which team members had completed reading the SOPs and any incomplete training was flagged to the store manager.

Pharmacists completed a daily check to ensure fridge temperatures were recorded, the responsible pharmacist (RP) notice was displayed, and the weekly CD balance check had been completed. As part of this all pharmacists were also required to record their checking initials.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were brought to the attention of the team member who had dispensed the medication and the mistake was recorded electronically by the team member. Each month a patient safety review was completed after which the team were briefed on the findings and next steps. The notes from the review were displayed on a board in the dispensary. As part of previous reviews team members had been asked to re-read specific SOPs and completed some retraining. Near misses were observed to be consistently recorded. For medicines which looked-alike or sounded-alike prompts had been added on the shelves to remind the team members to take care when picking these. Dispensing errors were reported online. Team members explained that there had not been a dispensing error for a while and were able to describe the process they would follow in the event that there was one reported.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. It had a complaints procedure and the pharmacist tried to resolve any complaints in store where possible. Complaints were reported to head office and passed on to the store manager who then investigated as well as speaking to the person who had raised the concern.

Records for private prescriptions, emergency supplies, unlicensed medicines, RP records and controlled drug (CD) registers were well maintained. CDs that people had returned were recorded in a register as they were received. CD balance checks were completed at regular intervals.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in a way to ensure people's private information was out of sight of the public. Team members all

completed mandatory annual training about information governance. Team members who needed to access NHS systems had individual smartcards. Pharmacists had access to Summary Care Records and consent to access these was gained from people verbally. Confidential waste was separated into designated bags and sent to head office for destruction.

Pharmacists had completed level two safeguarding training and other team members had completed the Boots mandatory training about safeguarding, electronically. Contact details were available for local safeguarding boards and safeguarding posters were displayed in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy is good at helping staff keep their knowledge and skills up to date. Team members get regular feedback and they are supported when doing accredited courses. The pharmacy has enough trained staff to provide its services effectively. They can raise any concerns or make suggestions and can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

At the time of the inspection the team comprised of the RP who was the regular store-based pharmacist, a trained dispenser and a trained health care assistant (HCA). A dispenser had stopped working for the pharmacy, and a new dispenser was due to start working there soon. The RP felt that as one of the dispensers had just left it was sometimes busier in the evening. However, she felt once the new dispenser started in June things would get better. Occasionally there were also issues with cover on the healthcare counter, but the dispensers supported with this. Team members described how there were two customer advisors who worked on the shopfloor. Both were healthcare trained and one was also a trained dispenser, and they were able to provide support when needed.

The HCA was observed to counsel people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She would refer to the pharmacist if she was unsure. She was aware of the maximum quantities of medicines that could be sold. To keep up to date, team members completed ongoing training. Team members also completed training on the e-learning platform. Deadlines were set for when team members needed to complete the training by. Digital records were kept and progress on completion was monitored by the store manager. E-learning modules included mandatory training on health and safety, safeguarding and information governance. Team members were provided with time to complete training in store. Team members who were completed formal training courses had an assigned tutor who ensured that the trainee had time to complete their training but also made time to ensure that they could go over the training material and help with any queries. The tutor asked questions to test the trainees understanding and made sure that they are up to date with their learning.

The pharmacy team received a monthly Professional Standards bulletin from the superintendent's office. This also covered learning from errors and included case studies. Team members were all required to read thorough this and sign once they had done so. The dispenser was the 'champion' and quizzed colleagues on their understanding as well as verbally briefing the team to reinforce the information contained within the bulletin.

Staff performance was managed by the store manager who carried out reviews with all team members. The RP also gave team members immediate feedback. Pharmacists had quarterly action plan meetings with the store manager. Team members felt able to make suggestions and give feedback. The team held team debriefs before the start of shifts to go over tasks that needed to be completed. The two pharmacists who worked at the store would catch up on the occasions where there was an overlap between them. The team also used a communication book and board to pass on messages to colleagues working different shifts. Meetings were held with the store manager if there was any information that needed to be communicated. The RP also tried to have a weekly meeting with the pharmacy team. Information from head office was received electronically. Targets were set for the

services provided, however team members said they did not feel any undue pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean; there was ample workspace which was clear and tidy and was allocated for certain tasks. There were designated areas for storing prescriptions waiting for stock or an accuracy check and the shelves were clearly labelled. Medicines were stored on shelves in a tidy and organised manner. A clean sink was available in the dispensary. A contracted cleaner cleaned the floors and sink daily and the dispenser preferred wiping down surfaces. The room temperature and lighting were adequate for the provision of healthcare. The store temperature was regulated. The premises were kept secure from unauthorised access. The pharmacy was open shorter hours then the rest of the store and was kept secure from unauthorised access.

A clean, signposted consultation room was available. This was easily accessible. The room was small but allowed for conversations to be held inside which would not be overheard. The room was locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy takes steps to ensure that people with a wide range of needs can access its services. It provides its services safely and manages them well. And it dispenses medicines into multi-compartment compliance packs safely. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

Consideration had been given to ensuring that the pharmacy services were accessible to all patients. There were a number of steps within the store from street level to access the main shop. A lift was available. Aisles were wide with clear access to the pharmacy counter. A hearing loop was also available, and the pharmacy had the ability to produce large print labels. Some team members were multilingual, and their name badges showed the additional languages they were able to speak. The dispensary team were able to see the entrance from the dispensary and would go and help anyone who required assistance. Appointments could be booked using an online diary system and some services were also provided on a walk-in basis. People were signposted to other services were appropriate. Team members had knowledge of the local area and signposted people to other stores which provide the services and cards were also available for other services including private GP surgeries that were given to people if they were not registered with a GP and needed medical assistance.

The RP felt the chicken pox vaccination service had the most impact. She mentioned that the service was very popular, and this was seen during the inspection. The RP described that not many branches provided the service and many people travelled from a distance to have the vaccination. The diary for the provision of the service was open all day so there was a lot of availability.

Most prescriptions were received electronically by the pharmacy. Prescriptions for antibiotics and acute medicines such as anti-inflammatories were processed and dispensed straight away, and people were sent a message once their prescription was ready. In the event that the pharmacy did not have the person's contact number they contacted the surgery and asked them to contact the person. Other prescriptions were entered onto the system and stock was ordered. Once the stock was received the labels were printed and medicines dispensed. The labelling system required barcodes from the medicine packs to be scanned in order for the label to be generated. Dispensing audit trails were maintained. Team members signed the quadrant stamps printed on the prescriptions forms to identify who was responsible for dispensing, accuracy checking, clinical checking and handing the prescription out. Dispensed and checked by boxes were also available on the labels which were used by all team members. Plastic tubs were used to separate prescriptions to prevent transfer between patients.

Pharmacist Information Forms (PIFs) were used to flag services suitable for the person and to highlight any clinical issues or changes to the prescriptions. These were printed automatically when labelling; hard copies were also available for team members to handwrite any additional notes. Team members used laminate cards to highlight prescriptions for CDs, fridge lines, and for medicines such as methotrexate, lithium and warfarin. These cards had question prompts at the back for information to check with the patient. Other laminates were available for 'refer to pharmacist' and paediatric

prescriptions. The pharmacy team also used a communication book to pass on messages.

Team members and the RP were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). People in the at-risk group who were not part of a PPP would be referred to their prescriber. Sodium valproate was usually dispensed in its original pack. Team members were aware of the need to attach a warning label and provide people with the information card any time sodium valproate was dispensed. Team members had also completed an e-learning module on dispensing sodium valproate and described using a 'refer to pharmacist' card when labelling sodium valproate. Additional checks were carried out when people collected medicines which required ongoing monitoring. For medicines such as methotrexate and warfarin a specific laminate was attached to the prescription which prompted team members of the checks they were required to complete. The company also had specific SOPs on dispensing and supplying these medicines. The pharmacist described the checks that would be carried out and information was then recorded on the person's electronic record. In the event that the dispenser carried out the checks they passed on the information to the RP.

The dispenser was very experienced and had worked as a dispenser for a number of years. She gave an example of where someone had been prescribed more than the recommended dose of citalopram which she had picked up, this had been flagged with the RP and raised with the prescriber and the team were waiting for a new prescription. In another instance the dispenser had picked up that someone had been prescribed methotrexate to be taken three times a day, when she had queried this, it had been found that the prescriber had meant to prescribe the antibiotic metronidazole. The dispenser always checked with people if they had taken medicines before and the dosages they usually took. Team members also described how in the past they had helped people source prescriptions from their regular GP when they had preferred specific brands.

Signed and in date PGDs were available for the services provided. SOPs for the relevant service were kept alongside the PGD. Pharmacists were required to complete online training as part of the accreditation and had face-to-face training for the vaccination training which including anaphylaxis.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. Team members were able to describe the steps they would take if the temperature fell outside of the required range. CDs were kept securely. Date checking was done routinely with a section checked each week. No date-expired medicines were seen on the shelves checked. A date-checking matrix was available. Short-dated stock was labelled, and a record was also made. Short-dated stock was removed in the second week of each month. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors. Drug recalls were received electronically from head office on the computer system, the system was updated two to three times a day. The pharmacy team had specific allocated times for checking for alerts through the course of the day. Once they were actioned team members were required to update the system. Alerts were also printed and filed in the dispensary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely and maintains it appropriately. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had glass, crown-stamped measures, and tablet counting equipment. Equipment was clean and ready for use. Separate labelled measures were available for measuring liquid CD preparations to avoid cross-contamination. The pharmacy had two medical grade fridges and a legally compliant CD cabinet. One of the fridges was in the dispensary and the other in the staff room. Blood pressure monitors were available, team members said these were replaced regularly. Up-to-date reference sources were available including access to the internet. Computers were all password protected and screens faced away from people using the pharmacy.

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.