General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Wood Green Shopping Centre, 137-139 High Road, LONDON, N22 6BA

Pharmacy reference: 1040524

Type of pharmacy: Community

Date of inspection: 14/02/2023

Pharmacy context

This pharmacy is situated in a shopping centre in a large Boots store. There is also an optician within the store. As well as dispensing NHS prescriptions the pharmacy provides a flu and covid vaccinations. It also provides the New Medicine Service and Community Pharmacist Consultation 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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
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 appropriately identifies and manages the risks associated with its services. And team members work to written procedures to help them provide the services safely. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well. And team members understand their role in protecting vulnerable people. The pharmacy keeps the records it needs to by law, to help show that it supplies its medicines safely and legally.

Inspector's evidence

Standard operating procedures (SOPs) were available and were up to date. Team members were required to read SOPs via the e-learning platform and were required to complete an assessment at the end to test their understanding. Team members explained that they needed to obtain a certain percentage to pass the module. Hard copies of SOPs were also available. The store manager was able to check which team members had completed reading the SOPs. Locum pharmacists were required to read SOPs on an electronic portal.

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). When a near miss was identified it was discussed with the team member who had dispensed the prescription and rectified. A record was then made on the electronic system. Near misses were recorded consistently. A monthly patient safety review was completed by a dispenser and the findings from this were discussed with the team. Team members explained how they had noticed the number of near misses had decreased after the company had introduced a new system for dispensing medicines as it required all items to be scanned before a label was printed. Most near misses that occurred now largely involved dispensing the incorrect quantity and near misses involving split packs. As a result, team members had been briefed to double check quantities when dispensing and ensure all split packs were marked. When recording near misses team members were required to identify if the mistake had included medicines that looked-alike or sounded-alike. Dispensing errors which reached people were investigated and recorded electronically with a copy submitted to the head office team. The pharmacy team received a monthly Professional Standards bulletin from the superintendent's office. This also covered learning from errors. Team members were all required to read thorough this and sign once they had done so. Copies were also available electronically.

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 investigated and reported electronically. Most feedback was received online.

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 annual training about information governance. Most team members had individual smartcards to access NHS systems. 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. In addition to this team members had also completed the level three eLearning for healthcare (eLfH) training. Contact details were available for local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely, and they do the right training for their roles. They do ongoing training and can get time to do this at work, which helps them keep their knowledge and skills up to date. They feel comfortable about making suggestions or providing any feedback. And they have regular team discussions to help them improve the pharmacy's services.

Inspector's evidence

At the time of the inspection the team comprised of the RP, a locum pharmacist. Two trained dispensers and a trained health care assistant (HCA). A second pharmacist was also there for part of the inspection and was due to become the regular store-based pharmacist. The pharmacy had not had a regular store-based pharmacist since July 2022. The store manager and assistant manager were trained dispensers and helped when needed. The RP felt that there were an adequate number of staff. Between 9am and 10.30 each morning the dispensers worked in both the dispensary and covered the medicines counter.

The HCA counselled 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. e-learning modules included mandatory training on health and safety, safeguarding and information governance. Team members were provided with time to complete training either in store or were given time back if it was done at home. Representatives from different companies also provided team members with training on products that were sold over the counter.

Staff performance was managed by the store manager. Previously, formal reviews had been carried out, but team members described how there was more of an informal procedure now. The RP also gave team members immediate feedback. Team members felt able to make suggestions and give feedback. The team held weekly huddles; these included the store manager. During the huddle the store manager briefed the team on how they were doing, what needed to be done and what needed improving. Team members also used their personal company email accounts to communicate. Targets were set for the services provided, however team members said they did not feel any undue pressure to achieve these. Locum pharmacists were not set any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. The pharmacy has designated areas for doing different tasks to help it manage its workflow. 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. A workstation at the front was used for labelling and dispensing prescriptions with one or two items. Medicines were stored on shelves in a tidy and organised manner. A clean sink was available in the dispensary. Cleaning was carried out by the team members and a contracted cleaner. 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.

A clean, signposted consultation room was available. The room allowed for conversations to be held inside which would not be overheard. The room was locked when not in use. The RP said that people were not left unattended in the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It takes steps to help ensure that people with a range of needs can easily access the pharmacy's services. It obtains its medicines from reputable sources, and it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

Consideration had been given to ensuring that the pharmacy services were accessible to all patients. The pharmacy was situated in a shopping centre there was step-free access into the store and both the shopping centre and store were accessible to mobility aids. Aisles were wide with clear access to the pharmacy counter. A lowered counter was available. A hearing loop was also available, and the pharmacy had the ability to produce large print labels.

The local area was diverse with a number of languages spoken locally. Most team members were multilingual and, on some occasions, asked other store colleagues to assist with translating. In some circumstances electronic translation applications were used. Services were advertised using posters and leaflets. People were signposted to other services were appropriate. The team used the internet and NHS websites to find information of other local services. The dispenser had called other local pharmacies to find out who offered a blood pressure checking service as the pharmacy had received a number of requests from a number of people. Since the last inspection the pharmacy had stopped providing a number of additional services. Team members explained that management were due to relook at the services that were being provided and see if there were any new services which could be offered.

Team members felt that the covid vaccination service had an impact on the local population. During the winter the pharmacy had been very busy providing the flu and covid vaccinations. There was now a lesser demand and so the service was offered on one day a week.

Most prescriptions were received electronically by the pharmacy. Prescriptions for antibiotics were processed and dispensed straight away. 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. If the system did not recognise the barcode the dispenser would ask a colleague to check and annotate the prescription form which would alerts the pharmacist when they completed the accuracy check. 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. The pharmacy team also annotated the bag label with the initials of the person who had bagged the medicines and the team member who handed out the prescription. 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 RP was 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. Team members had also completed an e-learning module on dispensing 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 RP mentioned that there was no one who collected warfarin from the pharmacy.

The pharmacy team did not reorder prescriptions on behalf of people from their surgery. People were referred to either the Boots or NHS websites where they could do this themselves. Team members assisted elderly people who were unable to do this.

The pharmacy had reviewed the service whereby it supplied medicines in multi-compartment compliance packs. Team members explained how they had one-to-one conversations with people using the service. Following these conversations, some people had decided to transfer to other nearby pharmacies and others had decided to have their medicines dispensed in the original packs.

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. 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. 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 and also on the store's NHS email account. Once they were actioned team members were required to update the system.

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 private information safe.

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. 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.