General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 173-175 Camden High Street, Camden, LONDON, NW1 7JY

Pharmacy reference: 1040535

Type of pharmacy: Community

Date of inspection: 21/06/2023

Pharmacy context

The pharmacy is on a busy high street in a residential area in northwest London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. Services include community pharmacist consultation service (CPCS), new medicines service (NMS), supervised consumption and seasonal flu vaccinations.

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	N/A	N/A	N/A
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's working practices are generally safe and effective. Members of the team follow clearly written instructions to help them manage risks and work safely. They highlight prescriptions for high-risk medicines so they can make sure people use them properly. The pharmacy's team members record their mistakes to learn from them and take appropriate action to stop the same mistakes happening again. The pharmacy keeps the records it needs to show that medicines are supplied safely and legally. The pharmacy team members protect people's privacy and understand how they can safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes on the pharmacy's online reporting system. They reviewed and discussed the near misses regularly to spot patterns and trends to learn from and reduce the chances of the same mistakes happening again. Team members explained that medicines involved in incidents or were similar in some way were generally separated from each other in the dispensary. The pharmacy team had separated the different strengths of atorvastatin tablets and omeprazole tablets and capsules to reduce the chance of picking medicines incorrectly. The monthly patient safety review had been completed and was displayed so the team could read it. A member of the pharmacy team explained that with the introduction of the current computer system, the prescription barcodes and medicine pack bar codes were scanned as part of the dispensing process. If a member of the team picked and scanned an incorrect item, the computer alerted the team. This function had reduced the number of mistakes in the dispensing process. The pharmacy displayed a 'model day' poster to help the pharmacy team complete tasks and manage their time throughout the day. The pharmacy's head office produced a monthly bulletin of patient safety information which the pharmacy team members read and signed. They had completed e-learning topics, generally about improving patient safety, for the pharmacy quality scheme (PQS).

Members of the pharmacy team responsible for making up people's prescriptions used tubs to separate each person's medication and to help them prioritise their workload. The prescription and any associated paperwork were kept together in the tub with the medicines until the final check. A member of the team completed a pharmacist's information form (PIF) for each person's prescription. The PIF alerted the pharmacist to consider recorded information when checking the prescription such as allergies, supply of high-risk medicines and outstanding medication. The pharmacy team added colour-coded laminated cards to highlight prescriptions with high-risk medicines such as those requiring therapeutic monitoring or counselling by the pharmacist. Team members referred to the prescription when labelling and picking products. They scanned the barcode on each pack of medication and the pharmacy computer system alerted them to packs of medicine which had been selected incorrectly. Scanning was not effective unless all packs were scanned rather than scanning one pack and multiplying by the prescribed number of packs. The team initialled dispensing labels to identify who dispensed and checked the medicines. Each prescription was endorsed and initialled by the team members to show who entered data, dispensed, checked and handed out the medicines to people. Assembled prescriptions were not handed out until they were clinically and accuracy checked by the pharmacist. The responsible pharmacist (RP) checked interactions between medicines prescribed for the same person and interventions were recorded on the patient medication record (PMR). The RP explained that

the prescriber would be contacted if necessary, by phone or email and a record was attached to the PMR for future reference.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last visit. Members of the pharmacy team accessed SOPs relevant to their role which they had to read and sign to show they understood them and would follow them. One member of the team explained how they verified someone's identity before handing out prescription medicines. And a member of the team explained the sales protocol for selling pharmacy only (P) medicines. The pharmacy's head office monitored training completed in the SOPs and it was up to date at the time of the visit. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A pharmacy advisor explained that prescriptions would not be given out or P medicines sold if the pharmacist was not on the pharmacy's premises.

The pharmacy had completed risk assessments for the services provided. And the team had completed risk assessment training in line with the pharmacy quality scheme (PQS). The pharmacy monitored the safety and quality of its services. The pharmacy team had completed clinical audits such as people taking valproates, antibiotics, inhaler technique and anti-coagulants required by the PQS. The pharmacy had a complaints procedure and people using the pharmacy could provide feedback via cards distributed by the team or the instructions on the back of the till slips.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The RP who signed in for the day also recorded fridge temperatures and completed the CD key log. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained controlled drug (CD) registers, and its team kept the entries up to date. And checked the stock levels recorded in the registers weekly in line with the CD SOPs. A random check of the actual stock of one CD matched the recorded amount. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically.

The pharmacy was registered with the Information Commissioner's Office. Its team completed information governance training annually and tried to make sure people's personal information could not be seen by other people and was disposed of securely. Members of the team used their own NHS smartcards and had their own log-in details to use the pharmacy computer. The pharmacy had a safeguarding SOP and the team had completed safeguarding training. The RP had undertaken level 3 safeguarding. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The pharmacy displayed safeguarding information and the 'Ask for ANI' flowchart in the dispensary so people experiencing domestic abuse could access a safe space if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload while they are recruiting more members. They are comfortable about providing feedback on how to improve their services. They pharmacy encourages them to undertake ongoing learning relevant to their roles supporting them in keeping their skills and knowledge up to date.

Inspector's evidence

The pharmacy team had one regular pharmacist from another branch who covered Sunday opening hours. But locum pharmacists covered shifts for the rest of the week until a newly recruited full-time pharmacist commenced employment at the pharmacy. The team consisted of four part-time pharmacy assistants (PAs) covering the dispensary and medicines counter, and one part-time and one full-time medicines counter assistant. Two part-time pharmacy assistants had been recruited for Saturdays and Sundays. The team had one further full-time vacancy to fill. During the visit, a member of the team on the retail side occasionally helped at the medicines counter and enrolling them on accredited training was discussed. PAs were trained to dispense and sell medicines over the counter (OTC). The pharmacy team members covered each other's absences when needed. A member of the team explained that the team were catching up on some tasks which had fallen behind due to the staffing situation which the manager said was being resolved following successful recruitment. The pharmacy team had a business continuity plan to follow if the locum pharmacist did not arrive. And the pharmacy had suspended some services until the pharmacy team had enough members.

The pharmacy team members had their own training profiles online and they could access training topics such as SOPs relevant to their role. The pharmacy's head office maintained training records for members of the team. Members of the team completed training via e-Learning for Healthcare (elfh). The team completed e-Learning which included mandatory topics such as information governance and PQS topics such as cancer awareness, weight management and antibiotic stewardship. Team members were able to undertake training during protected learning time and had recently re-trained in dispensing SOPs. Members of the team worked well together to serve people quickly and process their prescriptions safely. The pharmacy had an OTC sales procedure which members of the team needed to follow when people asked for a specific medicine. This described the questions they needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. The pharmacy displayed information on symptoms people might describe for the team to refer to.

Team members had regular appraisals to monitor performance and identify training needs. They had team meetings to discuss updates in services and they communicated via a WhatsApp group. The pharmacy team was able to provide feedback on improving the pharmacy's services and had suggested freeing up valuable dispensary space by moving slow-moving bulky items such as Ensure to a different location. Team members described having an open relationship but they had a whistleblowing policy they could use too.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean and suitable for the provision of healthcare. The pharmacy is secured when it is closed to protect people’s private information and keep the pharmacy’s medicines safe.

Inspector's evidence

The registered pharmacy premises were generally clean and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The public area of the pharmacy was much larger in area than the dispensary. The medicines counter and the dispensary were both on the same level at the back of the retail area and people had access to a consultation room which protected people’s privacy. The pharmacy displayed posters explaining how to deal with needlestick injury and fainting.

People wanting to have a private conversation with a team member were directed to the consultation room. The pharmacy had a health information display. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. And records were maintained of cleaning routines. The dispensary benches were limited in area and were divided into workstations for dispensing and checking.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy tries to make sure its services are easily accessible to people with different needs. Its working practices are safe and effective. And it obtains its medicines from reputable sources so they are fit for purpose. Pharmacy team members pro-actively highlight prescriptions for high-risk medicines and make sure people get the information they need to use their medicines safely. They store medicines securely at the right temperature and they keep records of regular checks to show medicines are safe to use. The team know what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had two wide entrances with automated doors at one entrance. And its entrance was level with the outside pavement. This made it easier for someone who used a wheelchair, to enter the building. The pharmacy team members tried to make sure people could use the pharmacy's services. They were able to print large font labels for people who were visually impaired and there was a hearing loop to help people with difficulty hearing. The team could speak or understand French and Spanish to help people whose first language was not English.

Members of the pharmacy team were helpful and they signposted people to another provider if a service was not available at the pharmacy. The pharmacy provided the community pharmacist consultation service (CPCS) dealing with referrals from NHS 111. The pharmacists offered the new medicine service (NMS) to people to help them take their new medicines in the best way. They followed up the first conversation at set intervals in the pharmacy or by phone if the person preferred. And resolved problems such as side effects that might result in the person not taking their new medication.

Members of the pharmacy team added colour-coded laminated cards to prescriptions to highlight high-risk medication and speak to the person collecting it. There was a procedure for dealing with outstanding medication. The team members were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had valproate educational materials to give to people to support them taking their medicines. The PAs were trained to give out prescriptions and check and record therapeutic monitoring values. For instance, the laminated card for supplying warfarin had questions on the reverse to ask the person collecting the warfarin. A member of the team was able to demonstrate where the blood test details were recorded on the PMR. The pharmacy usually provided the flu vaccination service via a patient group direction (PGD) for people. Team members had undertaken safeguarding training at an appropriate level to provide their services. The flu vaccination service had been suspended by the pharmacy during the winter Dec 22/Jan 23.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging. The pharmacy team was able to keep the dispensary benches clear as they completed prescriptions. They checked the expiry dates of medicines according to a matrix and highlighted short-dated medicines. In a random check no date-expired medicines were found. The pharmacy stored its stock which needed to be refrigerated in a fridge and kept records to show the temperature was between two and eight degrees Celsius. And it stored its CDs, securely in line with safe custody requirements. The pharmacy had procedures for handling the

unwanted medicines people returned to it. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And a team member demonstrated how the pharmacy dealt with a concern about a product. They printed the alert, checked stock for affected batches and annotated the alert before filing it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had glass measures for use with liquids and it had a fridge to store pharmaceutical stock requiring refrigeration. Its team regularly checked and recorded the maximum and minimum temperatures of the fridge. The pharmacy recorded information relating to equipment checks.

Confidential wastepaper was disposed of appropriately. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they entered their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team and team members used their own NHS smartcards.

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.