General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 191 Haverstock Hill, LONDON, NW3 4QG

Pharmacy reference: 1040574

Type of pharmacy: Community

Date of inspection: 15/11/2022

Pharmacy context

The pharmacy is located in a parade of businesses in a residential area near the Royal Free Hospital in north west London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include community pharmacist consultation service (CPCS), new medicines service (NMS), pneumococcal and seasonal flu vaccinations.

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	1.1	Good practice	Members of the pharmacy team actively manage the risks associated with providing services to protect the safety and wellbeing of people who use the pharmacy.
		1.2	Good practice	The pharmacy team members continually monitor the safety and quality of the pharmacy's systems and procedures so the services they provide remain safe.
2. Staff	Standards met	2.2	Good practice	The pharmacy supports and encourages its team members with regular training to keep their knowledge and skills up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy team members take extra care to highlight high-risk medicines and help to make sure people use these medicines safely.
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 safe and effective. Members of the team follow clearly written instructions to help them manage risks and work safely. They mark 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 has suitable business continuity arrangements in place so it can deal with an emergency. And it 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. The pharmacist reviewed them regularly to spot patterns and trends to learn from and reduce the chances of the same mistake happening again. The pharmacist discussed the near misses with the rest of the team. Team members explained that medicines involved in incidents or were similar in some way were generally separated from each other in the dispensary. Warfarin tablets were stored separately according to the colour of their manufacturer's packaging, and packs of zopiclone 7.5mg and 3.75mg tablets were stored in labelled containers. There were shelf-edge alert cards to highlight pairs of similar medicines. The pharmacy displayed a 'model day' poster which helped the pharmacy team complete tasks and manage 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. The current bulletin featured patient safety when administering flu vaccinations to vulnerable patients and information about elearning to be completed 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. They completed a pharmacist's information form (PIF) for each person's prescription. The prescription and any associated paperwork were kept together in a clear, plastic wallet in the tub with the medicines until the final check. 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. The dispensary benches were clean and tidy. 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 pharmacist checked interactions between medicines

prescribed for the same person and interventions were recorded on the patient medication record (PMR).

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last inspection. 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. 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. The most recent training had been in responsible pharmacist (RP) procedures. The trainee pharmacy advisor explained that prescriptions would not be given out or 'pharmacy only' medicines sold if the pharmacist was not on the pharmacy's premises.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. To help protect against infection, the pharmacy had cleaning products to clean surfaces, screens at its counters and hand gel for people to apply. The floor was marked so people could keep a distance from each other and personal protective equipment (PPE) was available for the team members. The pharmacy manager had completed risk assessments such as dealing with fire hazards or changes in SOPs and the risk assessments were updated when necessary. A member of the team explained to visitors upon arrival what to do in the event of a fire during the visit. The pharmacy team had an emergency bag to bring with them in the event of evacuation from the pharmacy's premises. It contained a business continuity plan along with useful items such as contact details for next of kin and outer garments for the team to wear. The pharmacy monitored the safety and quality of its services. The pharmacist submitted clinical governance and audit information via a portal on a weekly basis. The team undertook clinical audits such as people taking valproates, inhaler technique and anti-coagulants in line with the pharmacy quality scheme (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 responsible pharmacist (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 had 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 SOP. 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 pharmacist was undertaking 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 pharmacist described how the pharmacy could provide a safe space for people who gave a codeword to a team member.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. Team members work well together to manage the workload and they are able to provide feedback to improve services. They are actively encouraged to undertake ongoing learning relevant to their roles keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy team consisted of one full-time pharmacist and two regular part-time pharmacists who covered shifts between them each week, one full-time dispensing assistant and four part-time pharmacy advisors (PAs) either enrolled on or completed accredited training. PAs were trained to dispense and sell medicines over the counter (OTC). The pharmacy team members covered each other's absences and locum pharmacists provided cover when needed.

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. Safeguarding information and training certificates were filed in the pharmacy duty folder. The teams completed eLearning which included mandatory topics such as information governance and topics they could choose to study. PQS topics such as risk, safeguarding and domestic abuse prevention had time limits for completion. Team members were able to undertake training with protected learning time but often studied in their own time. Pharmacists were supported to undertake independent prescriber training. The pharmacy team read the '30-minute tutor' which was a monthly programme and knowledge quiz about new OTC products, some linked to seasonal health matters.

Members of the team worked well together to serve people quickly and process their prescriptions safely. The pharmacist supervised and oversaw the supply of medicines and advice given by the pharmacy team. 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 for the team to refer to on a notice board in the staff area. For instance: health and safety procedures and daily cleaning guidance.

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 communications book and WhatsApp groups. The pharmacy team described an open culture and there was an anonymous survey which team members could access to provide feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright, 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 bright, 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 larger in area than the dispensary. At one end of the medicines counter, the pharmacy displayed recall posters relating to faulty retail goods. The medicines counter was at the back of the retail area and the dispensary was on the same level. The pharmacy had a consultation room which was signposted and it protected people’s privacy. There were posters explaining how to deal with needlestick injury and fainting and the pharmacist knew the location of the nearest defibrillator. People wanting to have a private conversation with a team member were directed to the consultation room. The pharmacy had a health information display about winter health. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. And records were maintained of cleaning routines. The pharmacy team had positioned a yellow A board to warn people that the floor was wet and may lead to falls.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had a wide entrance with an automated door. 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 Gujarati, Bangladeshi, Urdu and Punjabi to help people whose first language was not English.

The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team were helpful and they signposted people to another provider if a service was not available at the pharmacy. Most frequently people were signposted to the nearby Royal Free Hospital, doctor's surgery, or opticians. The pharmacy provided the community pharmacist consultation service (CPCS) dealing with referrals to treat minor ailments and make emergency supplies of medicines. And most referrals were at the weekend. 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.

The pharmacy supplied medicines in multi-compartment compliance aids to people who found it difficult managing their medicines. The pharmacy team re-ordered the repeat prescriptions on behalf of people who had their medicines in the compliance aids. The doctors' surgeries issued the prescriptions to the pharmacy and they were screened for changes in medication before being prepared. If there were any changes in medication the backing sheet record was reprinted. The pharmacist clinically checked the prescriptions, and ordered the stock. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided patient information leaflets (PILs) and a brief description of each medicine contained within the compliance aids. People had the information they needed to make sure they took their medicines safely.

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 provided the flu vaccination service via patient group direction (PGD) for people of 11 years and over. Team members had undertaken safeguarding training at an appropriate level to provide services. The pharmacist had signed a training log after completing training in first aid, vaccination technique and dealing with anaphylaxis. Guidance included administration of flu vaccinations to people who were on anticoagulant therapy. The pharmacist obtained consent and did the clinical assessment prior to the vaccination. The person was given a PIL, and their surgery was informed to update their records. There were adrenaline injector devices to treat anaphylaxis after the vaccine was administered. And appropriate disposal bins for sharps and clinical waste. The pharmacist knew where the nearest defibrillator was located.

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 a plastic screen on its counter to help protect against COVID infection and hand sanitiser for people to apply. And it had the personal protective equipment if needed. The pharmacy team had access to up-to-date reference sources. 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. 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.