General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 254 Earls Court Road, LONDON, SW5 9AD

Pharmacy reference: 1041044

Type of pharmacy: Community

Date of inspection: 29/01/2024

Pharmacy context

This pharmacy is located on a busy local high street in a touristic area of West London. The pharmacy mainly serves people who lived and worked in the local area. It receives most of its prescriptions electronically and provides the New Medicine and needle exchange services.

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 provides its services safely and it has written procedures for staff to follow. It records and reviews errors and shares the outcomes with the team. This helps prevent any reoccurrence and improve the processes at the pharmacy. It keeps the records it needs to by law and maintains them well. The pharmacy manages information to protect the privacy, dignity and confidentiality of people who receive its services. And team members complete annual training on safeguarding so that they know what to do if they have a concern about a vulnerable person.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) in place, and these were held electronically. Current team members had read the relevant SOPs.

Dispensing mistakes which were identified before the medicine was handed to a person, or near misses, were seen to be routinely recorded. Dispensing mistakes which reached people, or dispensing errors, were also recorded electronically and reported to the pharmacy's head office. The RP described a recent error, where a missed controlled drug (CD) instalment had been supplied. The RP said that the error had been reported to head office and the prescriber. He explained that he usually segregated missed doses but had been too busy on that occasion. He also marked uncollected instalments with 'NC' (not collected) to help reduce the likelihood of supplying these. The responsible pharmacist (RP) had recently started working and was not entirely sure how often patient safety reviews were carried out, and believed they were done weekly or monthly. The RP had not been involved reviewing any dispensing mistakes since starting. The RP said that scanning the medicine packs on the patient medication record (PMR) during the dispensing process helped reduce the risks of errors. He had identified that quantity errors were most common and had briefed the team to double check quantities when dispensing.

The correct RP notice was displayed, and the RP record was in order. The pharmacy had current professional indemnity insurance. Samples of records for the supply of unlicensed medicines, private prescription and emergency supplies were complete. CD registers were maintained in accordance with requirements. CD balance audits were carried out routinely and a random stock check of a CD agreed with the recorded balance in the register. The RP said that people could raise concerns or give feedback by contacting the pharmacy's head office. 'How did we do?' cards, directing people to an online survey, were displayed near the tills. The RP said that he was not aware of any feedback the pharmacy had received.

Team members had completed the company's mandatory eLearning modules on information governance, the General Data Protection Regulation and code of conduct. A consultation room was available for private conversations and services. Computers were password protected and access to the PMR system was via individual smartcards, but there was some sharing of smartcards. Confidential waste was stored in separate waste bags which were collected by head office.

All members of the team had completed the company's annual eLearning module on safeguarding vulnerable groups. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education module about safeguarding. The details of the local safeguarding board were printed out and stored in the pharmacy 'duty' folder, but these were dated from 2014, so may not be still relevant.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough staff to adequately manage its workload. Team members can raise concerns. They are provided with ongoing training. But they do not always have time set aside for training, which may make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

During the inspection, the pharmacy was staffed by a regular pharmacist and a dispenser. The pharmacist had started at the branch two months ago and was still familiarising himself with the pharmacy's processes. Two dispensers usually covered the Monday to Friday shift, but one was on leave during the inspection. The dispensary team also covered the medicines counter. Members of the team appeared to be struggling with the workload at times but said they usually managed well when a third dispenser was working. Queues built up at times and on occasion some people were observed waiting for prolonged periods of time without being acknowledged. The assistant manager, who was also a trainee dispenser, helped cover the dispensary later during the inspection. Another three part-time dispensers covered weekend shifts. A new store manager was due to start soon.

Staff appraisals were usually conducted once a year, but the dispenser said he had not had one for over a year. Members of the team were happy to raise concerns to the manager. Targets were set by head office, but the team felt that these were reasonable. Members of the team said that they kept their knowledge and skills up to date by completing eLearning modules as and when they could. Some team members said it could be difficult to fit training during working hours. The dispenser described some recent training they had completed, for example, about the new Pharmacy First service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is properly 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

The pharmacy had a large retail area. The dispensary was located at the back of the shop and could be accessed by a few stairs or an internal ramp. There was sufficient work and storage space. Fixtures were generally well maintained. There were designated areas for various tasks. Pharmacy-only (P) medicines were stored behind the medicines counter, which was beside the dispensary. A sink was fitted in the dispensary, but this needed to be cleaned. A cleaner cleaned the pharmacy daily.

A spacious consultation room was available for services and private conversations. The room was kept locked when not in use and was generally clean and tidy. A hatch and separator were fitted at one end of the dispensary, and allowed for privacy for people collecting their substance misuse treatment. A bell was fitted so that the pharmacy team could be alerted when someone was waiting. The cleaning was carried out daily by a cleaner.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has a range of systems to help it provide its services in a safe and organised manner. It highlights prescriptions for higher-risk medicines and if a person is prescribed a new medicine. It obtains its medicines from reputable sources, and keeps them secure and generally stores them properly.

Inspector's evidence

Access into the pharmacy was step-free and via an automatic door. There was ample space for people in wheelchairs and a ramp was fitted inside the shop to allow accessibility to the back of the premises. Lowered counters were fitted at the medicine counter and dispensary. The pharmacy's opening hours were clearly displayed, and leaflets were available near the dispensary and consultation room. There was one chair near the dispensary and another one near the collection hatch. The pharmacy was looking to start the new Pharmacy First service and team members were currently in the process of completing the relevant training.

Alert labels were printed out automatically by the PMR system, for example, if people had allergies or if a new medicine had been prescribed. These were seen to be attached to prescriptions. Prescriptions were attached to medicines awaiting collection, and this allowed for a three-way check when a person collected their medicine. The RP was observed asking the dispenser to print a patient information leaflet for a person.

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. The dispenser said he had been briefed about the valproate guidance and was aware of the need to provide original packs. He said that he would re-read the guidance to familiarise himself with additional advice to give people in the 'at-risk' group. The RP had not come across any person taking valproate who was in the 'at-risk' group.

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. CD instalments were dispensed in advance for the week to help minimise distractions. 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.

Medicines awaiting collection were stored in drawers and were cleared on a weekly basis to reduce clutter. People were sent text messages to remind them to collect their medication before the medicines were removed from the retrieval. Removed prescriptions were retained at the pharmacy until they expired, should the person return to collect the medicine.

Stock was obtained from reputable wholesalers and was stored tidily on the shelves. Expiry date checks were conducted on sections of the dispensary on a regular basis. Medicine with short expiry dates were

highlighted with a coloured sticker. Three packs of date-expired CDs were still mixed with other stock, though they had been marked with a 'short-dated' sticker. The fridge temperatures were monitored daily. Records indicated that the temperatures were maintained within the recommended range. An investigation form was completed if a temperature anomaly was identified. 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 right equipment and facilities it needs to provide its services. And it largely maintains them well.

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Measuring cylinders and tablet counting equipment were available but some triangles had tablet residue and needed to be cleaned. Cylinders used for certain medicines were clearly marked. Up-to-date reference sources were available including access to the internet. Two pharmaceutical fridges were used to store medicines requiring cold storage. Computers were password protected and screens faced away from people using the pharmacy. The pharmacy had a cordless telephone. Confidential waste was collected in separate waste bags.

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.