General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit LSU3 (121), The Centre Court Shopping Centre, 4 Queens Road, LONDON, SW19 8YE

Pharmacy reference: 1041233

Type of pharmacy: Community

Date of inspection: 27/05/2022

Pharmacy context

This is a large branch of Boots in the main shopping centre by Wimbledon mainline and underground railway stations. It dispenses people's prescriptions, sells over-the-counter medicines and provides health advice. It also offers a range of private healthcare services including travel health. It dispenses some medicines in multi-compartment compliance packs for people who find it difficult to manage their medicines.

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	Records of errors and near misses are made by the member of staff involved. They are then reviewed by the patient safety champion who discusses them with the pharmacist and the rest of the team to identify and share any learnings
2. Staff	Standards met	2.2	Good practice	Staff are encouraged to develop their skills and there are clear development opportunities as evidenced by the store manager's preference for promoting from within before recruiting externally
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 in line with detailed processes and procedures which are being followed by its team members. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps good records of the mistakes that happen during the dispensing process. And it has a 'patient safety champion' who regularly reviews them with the pharmacist and other members of the team so that they can learn from them and avoid problems being repeated. The pharmacy manages and protects confidential information appropriately. Its team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has appropriate insurance in place to help protect people if things do go wrong.

Inspector's evidence

The inspection was carried out after the majority of the COVID-19 related restrictions had been lifted. All members of the pharmacy team were wearing masks in accordance with the current government guidance for health and social care settings. The store manager was aware that workplace risk assessments had been carried out, but as they pre-dated her appointment to the store, she was unable to provide any further details.

There were Standard Operating Procedures (SOPs) in place to underpin all professional standards, seen as signed and read by staff. Staff roles and responsibilities were all set out in a matrix within the SOP folder, and staff were all able to explain what they do, what they were responsible for and when they might seek help.

Errors and near misses were recorded on a 'Near Miss Incident log' kept beside a noticeboard in the dispensary. The responsible pharmacist (RP) explained that one of the dispensing assistants was the 'patient safety champion,' and that she reviewed them regularly with the rest of the team The RP explained how all near misses and errors were recorded immediately by the individual team member involved. The reviews were an opportunity for all members of the team to learn from these mistakes and reduce the likelihood of them happening again.

The RP log was seen to be complete and up to date. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist notice was correct and clearly displayed for people to see. A certificate of professional indemnity and public liability insurance was held electronically on the company's intranet.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and all those inspected were complete with all the necessary details correctly recorded. Emergency supply records were also maintained electronically, although the pharmacy did not receive very many requests. The pharmacy did receive some requests via the Community Pharmacy Consultation Service (CPCS) and these were documented on the PharmOutcomes software package, which also ensured that people's GPs were notified.

Those sections of the controlled drug (CD) register examined were found to be correctly maintained.

Running balances were checked weekly in accordance with the SOP. Stock balances of two random samples were checked and found to be correct. Amendments to the records were asterisked with a signed and dated footnote to identify who had made the amendment. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed ‘specials’ were present with all of the necessary information recorded.

Those team members questioned were able to demonstrate an understanding of data protection and had undergone General Data Protection training. Confidential waste was kept separate from general waste and shredded offsite. Completed prescriptions awaiting collection were stored so that people’s personal details were not visible to those waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies for both adults and children were in the safeguarding section of the pharmacy duty log. All registrants had been trained to level 2 and all other staff members had undergone level 1 Boots e-learning. Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They work well together and can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There were two healthcare advisors, two pharmacy advisors (one of whom being the store manager), one trainee pharmacist and the RP, on duty during the inspection. Team members were seen to be working well together. In the event of staff shortages, they would adjust their working hours to cover each other. The manager explained how she would always try to promote team members from within before trying to recruit externally. All staff wore badges showing their names and role.

Certificates to confirm staff qualifications were available both online and in paper files to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. One of the healthcare advisors described some of the ongoing training available to help him keep up to date. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. All members of staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines.

The trainee pharmacist was nearing the end of her training and was shortly due to take the end-of-year online assessment. She appeared to be happy with the training and support she had been given and was looking forward to gaining a prescribing qualification in the future.

There were targets in place, but they appeared to be applied sensibly. Team members were involved in open discussions about their mistakes and learning from them. There was a whistleblowing policy available for staff if required.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a secure and professional environment for people to receive its services. They are easily accessible for people with a wide range of needs. The premises include a small, but adequate, private room which the team regularly uses for some of its services and for private conversations.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance from the shopping centre. The premises were clean and tidy with plenty of room for people with pushchairs or those with mobility issues. The dispensary itself was small with only limited workspace. But it appeared well organised, and the workstations were kept tidy and free of clutter.

There was a small consultation room for confidential conversations, consultations and the provision of services. There was no confidential information on view inside the consultation room. There was a password-protected computer used mainly for communicating patient information to the pharmacy’s online prescribers and for receiving electronic private prescriptions back from them. The door was kept securely closed when the room was not in use.

The sink in the dispensary was clean, with hot and cold running water and handwash available. Room temperatures were appropriately maintained by combined heating and air-conditioning units, keeping staff comfortable and suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner. It sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. Pharmacy team members identify people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. But they don't record all of those checks, which may make it harder to show what had been done if a problem were to arise in the future.

Inspector's evidence

There was a range of leaflets providing general health information and the services available from the pharmacy. The pharmacy provided a range of services in addition to dispensing NHS prescriptions.

Staff were observed serving people and dealing with their prescription requests. There was a selection of laminated prompt cards for specific types of prescription, for example those for babies and young children, or those for high-risk medicines such as warfarin. They prompted staff to check key safety information with the person collecting the prescription. They used baskets to keep individual prescriptions separate, and prescription labels were initialled to show who had dispensed and checked them. The system also endorsed the prescription tokens with prompts for the staff to sign showing who had labelled, clinically checked, assembled and completed the final check. Staff initialled the bag label on the finished prescriptions to complete the audit trail, signifying who had filled the bag and checked that it was complete and correctly labelled. Staff were observed checking people's identity before adding an extra signature on the bag itself to indicate who had handed it out. All of this helped to identify who had been involved at each stage in the process if any query arose after the prescription had been handed out. Owings tickets were in use when medicines could not be supplied in their entirety. The prescription was completed as soon as the missing item was back in stock.

The RP was aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled and provided with leaflets and cards highlighting the importance of having effective contraception. But the pharmacy was not currently documenting each intervention on the patient record. Upon reflection the RP agreed to remind people at each supply, and then record the intervention on the PMR. The same principles were discussed in relation to other high-risk medicines.

The pharmacy supplied some medicines in multi-compartment compliance aids to a number of people. There was a matrix to track the process, ensuring that the prescriptions were ordered from the surgeries on time. The matrix also tracked when the prescriptions were received, clinically checked, labelled, assembled and finally checked for accuracy. They worked to a four-week cycle, and kept records of each persons' medication, when they were taken, any known allergies, any discharge information from the hospitals and contact details. If anything changed, a new record sheet would be produced to reflect the new situation rather than simply changing the existing sheet. There were copies of the old sheets kept for reference behind the new ones. The labels included product descriptions to help people identify their medicines.

The pharmacy provided an online travel health service for travel vaccinations or antimalarials. The RP explained in detail how she conducted consultations in the consultation room, taking the patient through a number of predetermined questions. These included capturing the details of any medication the patient was taking, or any allergies they may have. The online form was then submitted to a pharmacist independent prescriber based remotely who would issue a prescription for the most appropriate medicine or vaccination. The RP would then dispense the prescription and supply that anti-malarial medicine or administer the vaccine. The patient would also be supplied with a summary of the consultation and further patient information such as the need to take effective precautions against being bitten by mosquitos or other helpful information. The private prescriptions issued through this service were appropriately recorded using the private prescription facility on the PMR system.

The pharmacy offered a selection of other services such as the cystitis test and treat service. The RP described how people would buy a test kit to use at home. Depending upon the result of the test, the pharmacist could then supply a suitable antibiotic such as nitrofurantoin using a patient group direction (PGD) as the legal basis for the supply. The pharmacist would notify the person's GP of the supply as part of their antibiotic stewardship. This was the only private service where the pharmacy automatically notified GPs. For all their other services, people were advised to inform their GP of any medicines or vaccinations provided privately. The pharmacy also offered yellow fever vaccinations and hepatitis B vaccinations, again using PGDs. These services were not examined in any further detail during the inspection.

The pharmacy acted as a collection point for prescriptions dispensed by the Boots out-patient pharmacy at Kingston hospital. There was a file containing details of prescriptions sent from the hospital for collection from the pharmacy. People's identity was verified before handing the medicines out. The pharmacist explained that they offered this service to save people the trouble of going back to the hospital.

The pharmacy also offered a COVID-19 PCR testing service. One of the healthcare advisors was trained to conduct the tests, which were collected at 3pm every day for analysis at an external laboratory. People would be notified of the test result either by email or online the following day. The pharmacy had been successfully accredited by UKAS, the government body responsible for regulating such testing services.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance. Unlicensed 'specials' were obtained from Alliance Specials. Routine date checks were seen to be in place, and record sheets were seen for each quarter. Items approaching their expiry date were recorded on monthly sheets, and any left in stock one month prior to expiry were then disposed of. There were records present for items due to expire each month up to and including September 2022. Part-used bottles of liquid medicines were annotated with the date upon which they were opened.

Fridge temperatures were recorded daily, and all seen to be within the correct temperature range. The fridge was almost full, but was tidy and clear of any frost or ice. Pharmacy-only medicines were displayed behind the reception counter to prevent self-selection of these medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients returning sharps were signposted to the local council for disposal. There was a tray containing protective gloves to help staff safely sort through any returned medicines. The pharmacy did not have a separate purple-lidded hazardous waste container for the disposal of medicines classified as hazardous waste. And there was no list of those medicines available for staff to refer to. The RP agreed to obtain a bin and list.

The pharmacy received drug alerts and recalls from the MHRA, printed copies of which were kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate facilities for the services it provides, and it keeps them suitably clean and tidy. It also ensures that people’s private information is kept safe and secure.

Inspector's evidence

The pharmacy equipment and facilities were seen to be appropriate for the services provided. The consultation room was clean and tidy. There was a range of standard glass conical measures, several of which were marked for use with methadone only. counting triangles (including a separate one for cytotoxics). There was one medicines fridge, and one CD cabinet. The pharmacy had online access to up-to-date reference sources.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen in use with no sharing of passwords.

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.