General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Units 31-32, Broadway Shopping Centre, Hammersmith Broadway, LONDON, W6 9YD

Pharmacy reference: 1041437

Type of pharmacy: Community

Date of inspection: 08/01/2024

Pharmacy context

This pharmacy is located in a small shopping centre, and above a train station, in West London. The pharmacy provides blood pressure testing and the flu vaccine service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing 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	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 manages its risks appropriately to make sure people are kept safe. It keeps the records it needs to by law. So, it can show that supplies are made safely and legally. Team members get training, so they know how to protect vulnerable people and the pharmacy manages and protects people's confidential information appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy. They were user-friendly and were also available in an electronic format. All current members of the team had signed the relevant procedures to confirm that they had read and understood them. The SOPs were reviewed annually by the superintendent pharmacist (SI) and annotated to reflect this. Responsibilities of team members were listed on individual SOPs.

Dispensing mistakes which reached people, or dispensing errors, were recorded electronically and reported to the pharmacy's head office. There had not been any for some time. Dispensing mistakes which were identified before the medicine was handed to a person, or near misses, were recorded electronically. A report was generated by the system at the end of each month, and this was used by the team to help identify any patterns or trends. Barcodes on medicine packs were scanned during the dispensing process to help minimise the risk of selecting the incorrect medicine, strength, or formulation. The team had identified that most near misses involved hand-written prescriptions. To help minimise the risk of these errors, the team were now confirming the prescription with the pharmacist or contacting the GP practice to clarify the prescription. The team had also separated some higher risk medicines, such as antidiabetic medication and quetiapine following some near misses.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) sign was clearly displayed, and samples of the RP record were in order. Private prescription and emergency supply records were held electronically, and these were in order. A sample of controlled drug (CD) registers was inspected, and these were seen to be well maintained. The physical stock of a CD was checked and matched the recorded balance. Balance audits were conducted on a weekly basis.

Members of the team handed out cards referring people to an online feedback form. The pharmacy had received some feedback with regards to managing the queues and, as a result, was in the process of training another medicine counter assistant. The technician added that the team tried to give realistic waiting times when processing prescriptions.

Team members completed the company's eLearning modules on information governance, General Data Protection Regulation and code of conduct, which were renewed annually. A consultation room was available for private conversations and services. Computers were password protected and access to the PMR system was via individual smartcards. Confidential waste was stored in separate waste bags which were collected by head office. The technician added that the team always ensured that prescriptions and medicines awaiting collection were not visible to members of the public.

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 (CPPE) module. Team members were aware of the 'safe place' initiative. The technician described a safeguarding case which had been flagged to the GP recently.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just about enough staff to provide its services safely. Team members work in a supportive environment and are provided with some ongoing training. But they do not always have time set aside to do it. This may mean they do not always have opportunities to keep their skills and knowledge up to date.

Inspector's evidence

During the inspection, there was a relief pharmacist, a registered technician, a trainee pharmacist, and a trainee medicine counter assistant (MCA). The pharmacy also employed a full-time dispenser, a part-time dispenser, and a part-time dispenser. The regular pharmacist, who was on annual leave during the inspection, had been working at the branch for 23 years. Relief pharmacists who worked across branches helped cover pharmacist days off and the store managed was also a trained dispenser so could help when needed. The pharmacy previously opened until 8pm but was now closing at 6pm following the pandemic. Staff shifts were clearly displayed in the dispensary to help identify who was covering at any one time.

Some members of the team said that it was quite challenging to keep on top of the workload during busier periods, however, they always managed to complete the required tasks, albeit the added pressure. They felt this more since starting the blood pressure testing service.

The trainee pharmacist was provided with seven and a half hours of study time each week. She had access to online training material and activities which included discussing patient cases, learning about the dispensing process, completing modules on business development and leadership, and observing colleagues. She discussed her progress with her tutor, the regular pharmacist, at least every two weeks. She said that she was happy to speak openly to colleagues and raise concerns to her tutor, who was very supportive. Other members of the team said that did not always have time to complete ongoing training during working hours, though every now and then they could complete an online module. Mandatory training was completed annually, and this covered topics such as information governance, health and safety, and safeguarding. Support staff said that the regular pharmacist liked to test their knowledge and always kept them up to date on changes and processes.

Appraisals were conducted annually where team members had the opportunity to discuss areas of improvement and training needs. Members of the team were also asked to complete an annual survey though some members did not feel their feedback resulted in any changes. Targets were set for services. Team members said these did not affect their professional judgement though there was always pressure to meet them from senior management.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and are mostly clean. People can have a conversation with a team member in a private area.

Inspector's evidence

The dispensary was located at the back of the store. The fixtures and fittings had not been replaced for some time but they were generally fit for purpose. The cleaning was done daily by a cleaner though some shelves were dusty. There was a sink available in the dispensary with hot and cold running water to allow for hand washing and preparation of medicines. Soap and paper towels were available. There was sufficient lighting throughout the premises. The store was relatively cold during the inspection, and although some portable heaters had been ordered, these had not made much of an improvement. A small consultation room was available for private conversations and services. The room was kept locked when not in use and was clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services and the pharmacy provides its services safely. The pharmacy highlights prescriptions for higher-risk medicines, so that there is an opportunity to speak with these people when handing the medicines out. The pharmacy manages its medicines well and appropriate action is taken where stock is not fit for purpose.

Inspector's evidence

Access into the store was step free and via a wide entrance. There was ample space in the retail area for people with wheelchairs and a lowered worktop was fitted at the medicines counter. Services were advertised in store and online. Team members said they verbally signposted people to services available at the pharmacy or to other pharmacies and healthcare providers. There were a number of leaflets displayed near the consultation room.

'Pharmacist information forms' (PIFs) were used to highlight any changes to a person's medicine, allergy status, or if a person was suitable for a particular service, such as the New Medicine Service. These were now generated automatically through the PMR system and attached to dispensed prescriptions. 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. Prescriptions were also scanned on the PMR system to confirm that they were supplied. This further helped minimise hand out errors.

Medicines awaiting collection were stored away from people's view and cleared on a weekly basis to reduce clutter. Prescriptions which were older than five weeks were removed and stored in alphabetical order should the person present later. CD prescriptions were sent back to the prescriber. People were sent text messages to remind them to collect their medication. Coloured stickers, annotated with expiry date of the prescription, were placed on prescriptions for Schedule 2, 3 and 4 CDs. This helped reduce the risk of supplying these medicines past the valid date on the prescription.

Higher risk medicines including sodium valproate, warfarin, and lithium were flagged up by the patient medication record (PMR). They were also highlighted with coloured laminates and PIFs. The coloured laminates listed all the relevant checks the pharmacy check should make before supplying the medicine. Team members had read the valproate guidance and were aware of the need to provide original packs. They said that the PMR system always rounded up to the original pack when generating labels. The pharmacy supplied this medicine to one person in the 'at-risk' group and had made the relevant checks with the prescriber.

A 'Medisure progress log' was used to keep track of prescriptions ordered for people receiving multi-compartment compliance packs. The log was ticked and dated to confirm when prescriptions had been ordered, processed, and collected. Prescriptions were cross checked with individual record sheets once they were received. Record sheets were clear and well organised. Drug descriptions were provided, and patient information leaflets were routinely supplied.

Stock was obtained from reputable wholesalers. Sections of the dispensary were date checked monthly and records were kept for these checks. Medicines with a short expiry date were marked with a

coloured sticker. No out of dates were found during the inspection. Waste medicine was disposed of in appropriate containers. These were kept in the dispensary and collected by a licensed waste carrier. Fridge temperatures were monitored and recorded daily, and temperature records examined were seen to be within the range required for the storage of medicines. Drugs alerts and recalls were sent from head office via the intranet. These were printed out, signed and filed for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There were two fridges were clean and suitable for the storage of medicines. Several clean, glass measures were available at the pharmacy, including separate measures for particular medicines. The pharmacy had tablet and capsule counters, with a separately marked counting triangle used for cytotoxic medicines. The blood pressure monitor was new and team members said this would be serviced annually. Waste medicine bins, destruction kits and sharps bins were available to dispose of waste medicine, CDs and needles respectively. These were stored securely.

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.