General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 41 King Street, Hammersmith, LONDON, W6 9HW

Pharmacy reference: 1041443

Type of pharmacy: Community

Date of inspection: 21/07/2022

Pharmacy context

This pharmacy is located on a busy local high street. The pharmacy dispenses NHS prescriptions and provides medicines to care homes. 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 the risks associated with its services. It keeps the records it needs to by law, so it can show that supplies are made safely and legally. People who use the pharmacy can provide feedback and the pharmacy team has received training to help protect the welfare of vulnerable people. When a dispensing mistake occurs, team members react appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available at the pharmacy. They were user-friendly and stored in an organised manner. Not all current members of the team had signed the relevant procedures to confirm that they had read and understood them. The store manager said that he preferred team members to read the SOPs in sections rather than inundate them with all the procedures at the same time. The SOPs had been reviewed recently and annotated to reflect this. Responsibilities of team members were listed on individual SOPs.

The pharmacy had made some changes because of the Covid-19 pandemic. Plastic screens had been fitted at the front counters. Personal protective equipment (PPE) and hand sanitizers were available and team members continued to wear face masks. This was a large store with ample space to support safe distancing measures. Members of the team cleaned the pharmacy throughout the day and signed a cleaning rota to confirm this. A staff risk assessment had been done at the start of the pandemic and team members had completed an eLearning module on infection control.

Dispensing mistakes which were identified before the medicine was handed to a person (near misses), were recorded electronically. These were reviewed at the end of every month and a 'Patient Safety Review' was completed. The store manager described some changes which had been made as a result of a near miss, for example, team members were now annotating 'Pharmacist Information Forms' (PIFs) with 'no barcode scan' if a medicine pack did not scan on the patient medication system. This helped ensure that a thorough check was conducted. The store manager added that near misses had reduced significantly since the new system was introduced as most medicines packs were scanned as part of the dispensing process. The team had also separated some higher risk medicines, such as methotrexate and quetiapine, following major incidents at other branches.

Dispensing mistakes which reached people (dispensing errors) were recorded electronically and reported to the pharmacy's head office. The store manager described a recent error where a person had been dispensed an antibiotic against a 2-week-old prescription, instead of a more recent prescription as this had been sent to another pharmacy. The pharmacy team had discussed the error and had been briefed to hold more thorough conversations with people to confirm their medicines.

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 complied with the requirements. Records about unlicensed medicines were stored in a designated folder and were completed correctly. Samples of controlled drug (CD) registers were inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

The manager said that people could provide feedback or raise concerns verbally or online. People were also provided with the contact details for the pharmacy's head office if requested. Care home staff could call the pharmacy directly or email the care homes unit. The pharmacy had not had an official complaint for some time.

Team members completed the company's eLearning modules on information governance, the 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 patient medication record (PMR) system was via individual 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. A 'safe place' poster was displayed at the front counter and team members described how they had provided a safe room and contacted the safeguarding team after a distressed person visited the pharmacy. The pharmacist had also followed up with the person's GP following the incident.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained or enrolled onto suitable courses for the jobs they do. Team members feel comfortable about raising concerns. They complete ongoing training to help keep their skills up to date.

Inspector's evidence

The pharmacy team comprised of a regular pharmacist, a trainee pharmacist, three accuracy checking technicians (ACTs), eleven dispensers, four trainee dispensers, and one trainee medicine counter assistant (MCA). Team members worked across the walk-in dispensary, care homes unit and multi-compartment compliance pack unit.

A business continuity plan was in place. The manager said that he was able to call on resources across the region when the pharmacy had been affected by short-term staff shortages during the pandemic. He said that the pharmacy had several members of the team who worked part-time but were able to work additional hours when needed. At one point, the area manager had also helped check medicines. Locum and relief pharmacists could also be booked in when needed.

The trainee MCA had excellent rapport with people and was observed asking a number of questions and providing counselling and advice when selling Pharmacy-only medicines. He said he observed dispensary team members as they worked to help learn about the processes as he wanted to complete a dispensing course once he finished the MCA one. He was aware of medicines open to abuse, such as codeine and laxatives, and provided additional advice when selling these.

The ACT said she was responsible for checking dispensed medicines in both the care homes and multi-compartment compliance pack units. She also helped check medicines in the walk-in dispensary during quieter weeks in the care homes unit. She checked medicines in a designated room next to the care home unit. This helped minimise distractions. She felt the care homes and multi-compartment compliance pack units were managed well and staffing levels were generally appropriate for the services provided. She explained that the care homes unit tried to supply medicines to the care homes one week in advance. This allowed for both the care home and pharmacy teams to deal with any issues or changes. The ACT completed ongoing training, for example, reading articles and accessing the company’s eLearning modules. She had been working at the company for 20 years so had a good network of colleagues and regularly held discussions with them. Team meetings were held once a week to plan the week ahead and discuss any issues, errors and learnings.

Team members said they were regularly provided with protected study time to complete eLearning modules. Trainee members of staff were also provided with time to complete their training modules. Performance reviews were conducted every three to six months. Team members said they had good working relationships and could approach each other, as well as the manager, to discuss any concerns or issues. They also had the opportunity to discuss their developmental needs, for example, a dispenser had discussed enrolling onto the technician course, and this had been approved by the manager. Some targets were set for the team, but team members felt that these helped ensure that people had access to services that may be beneficial to them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations with a team member.

Inspector's evidence

The store was large and had a spacious dispensary which was located towards the back. The dispensary had sufficient work and storage space, but work benches were slightly cluttered. There were several workstations, and each had a computer and the equipment required for the dispensing process. The consultation room was next to the dispensary and was kept locked when not in use.

A spacious room, which was located on the first floor was used as the homes unit. Another smaller room located just beside the care homes unit was used by the ACT to check dispensed medicines. This was fitted with a desk, a long workbench, and some shelves. Another spacious room was used to assemble multi-compartment compliance packs, and this was located next to the care homes unit. Access to the first floor was via a door which was fitted with a Digi-lock.

The premises were cleaned throughout the day by the team and at least once a week by a cleaner. The temperature was regulated by an air conditioning system and was suitable for the storage of medicines. There was good lighting throughout the premises. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services in an organised way and people can access its services. It obtains its medicines from reputable sources and generally manages its medicines appropriately. But it could do more to ensure that people taking higher-risk medicines are identified and provided with appropriate, up-to-date advice.

Inspector's evidence

Access into the store was step free and via several wide doors. 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. Leaflets were available in the waiting area and consultation room and team members said they verbally signposted people to services available at the pharmacy or to other healthcare providers. The pharmacy's opening hours had recently been changed and the pharmacy was now closing at 6pm rather than 8pm.

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 attached to all prescriptions dispensed in the walk-in dispensary or care homes and multi-compartment compliance pack units. 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 people's 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 in drawers and were 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. People were sent text messages to remind them to collect their medication. Coloured stickers, annotated with the expiry date of the prescription, were placed on prescriptions for Schedule 2, 3 and 4 CD's. This helped reduce the risk of supplying these medicines past the valid date on the prescription. Dispensed CDs and medicines requiring refrigeration were kept in clear plastic bags. This allowed for an additional check at hand-out.

The trainee pharmacist, who was working in the walk-in dispensary, was able to name several higher-risk medicines, such as lithium, warfarin, valproate and insulin. He described his checking technique, which included confirming the person's age and checking the dose in the BNF. He was aware of the at-risk group for valproate and described some of the checks he would make when dispensing this medicine, for example, checking if the person was on the Pregnancy Prevention Programme. He also supplied people in the at-risk group with a warning card or leaflet, and these were seen to be available at the workstations. Members of the team also checked INR levels of people taking warfarin but were not recording these on the person's medication record, in line with the pharmacy's SOPs. Several members of the care homes unit team were not aware of the at-risk group for valproate. They were dispensing valproate to a person in the at-risk group but had not made any appropriate checks or provided the warning cards. The manager said that he would ensure team members reread the valproate guidance and made the appropriate checks.

The care homes unit dispensed medicines in their original packs to 18 care homes, ranging from one bed to 80 beds. Care homes were arranged over four weeks. Prescriptions were ordered by the care

home staff but the pharmacy team also followed up with them to help ensure they were received in a timely manner. Prescriptions were received electronically and a 'missing items' list was sent to the care home if a medicine had not been prescribed by the GP. Any communications with care homes were recorded in a communications book. Prescriptions were clinically checked by a pharmacist before medication administration record sheets (MARS) were generated. Medicines were then picked and labelled against the prescriptions and MARS. These were then sent to the checking room to be checked and bagged by the ACT. Dispensed medicines were stored in delivery boxes labelled with the care home name and ticked to confirm they had been checked. Acute medicines or those prescribed mid-cycle were generally supplied on the same day. The electronic prescription system was checked throughout the day and these prescriptions were then prioritised by the care homes unit manager (a dispenser) or the dispenser in charge of processing acute prescriptions. The pharmacist was not always involved in the decision to prioritise acute prescriptions and the pharmacy did not always keep records of communications between them and the care home in the event that an acute prescription could not be delivered on the same day.

The pharmacy's head office had recently decided to switch people receiving multi-compartment compliance packs to original packs, if appropriate. The pharmacy previously dispensed packs to 75 people living in their own homes but was now supplying to 20. The manager or pharmacist held conversations with people and completed a medicines support tool to check if they could be switched to original packs. The tool involved asking a series of questions, for example, to check if the person had a family member who could help with their medicines. People were reviewed again once they were switched to original packs to help ensure that the correct decision had been made. Some people had been switched back to multi-compartment compliance packs following the review.

Part-dispensed medicines were stored in a disorganised manner in the care homes unit, with various medicines, strengths and formulations piled on top of each other. The manager said these were taken down to the walk-in dispensary at the end of the week. He said he would review their storage. Medicines were date checked weekly and records were kept for these checks. Medicines with a short expiry date were marked with a coloured sticker. Adrenaline pens, which had expired in April and May 2022, were found in the consultation room. These were removed and disposed of. Waste medicine was disposed of in appropriate containers. 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. The intranet was updated once the alerts were actioned by the pharmacy team.

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

The fridges were clean and suitable for the storage of medicines. Several glass measures were available at the pharmacy, including separate measures for particular medicines, but some were not clean. The manager said they would be cleaned after use. The pharmacy had tablet and capsule counters, with a separately marked counting triangle used for cytotoxic medicines. Waste medicine bins, destruction kits and sharps bins were available to dispose of waste medicine, CD's and needles respectively.

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.