General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Units 40-42, Brunswick Shopping Centre, Bloomsbury, LONDON, WC1N 1AE

Pharmacy reference: 1041540

Type of pharmacy: Community

Date of inspection: 10/12/2024

Pharmacy context

This is a community pharmacy in a shopping centre in central London. It dispenses NHS and private prescriptions and recommends over-the-counter medicines. Other services include: supervised consumption, blood pressure case-finding service, Pharmacy First 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	The pharmacy team have effective systems and procedures in place to help them identify and manage risks when they are providing services.
		1.2	Good practice	The pharmacy team review and monitor the safety and quality of the services they provide.
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	4.2	Good practice	The pharmacy services are effectively managed to make sure they are provided safely to people who use the pharmacy.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team member's working practices are safe and effective. And they follow clearly written instructions to help them identify and manage risks when they are providing services. They record and review their mistakes so they learn from them to help avoid making the same mistakes again. They have systems to highlight prescriptions for high-risk medicines so they can make sure people use them properly. The pharmacy keeps the records it needs to show that medicines are supplied safely and legally. The pharmacy team members protect people's private information 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. They reviewed and discussed the near misses regularly to share learnings and reduce the chances of the same mistakes happening again. Team members explained that medicines involved in incidents or were similar in some way were generally highlighted or separated from each other in the dispensary. An example being eplerenone and empagliflozin which had been separated. The monthly patient safety review (PSR) was completed by a team member who was patient safety champion and the team was encouraged read it. The PSR set out actions, how they were measured and if they were realistic and appropriate to prevent future similar mistakes. The team members had agreed to circle unusual quantities on labels and prescriptions. This alerted team members to be vigilant when dispensing and checking the corresponding medicines.

The responsible pharmacist (RP) explained that with the introduction of the current computer system, the prescription barcodes and medicine pack bar codes were scanned as part of the dispensing process. If a member of the team picked and scanned an incorrect item, the computer alerted the team. This function had reduced the number of mistakes in the dispensing process. Members of the pharmacy team recorded dispensing incidents such as mistakes with dispensed medicines which had left the pharmacy on the pharmacy incident reporting system.

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. If the prescriptions had been handed in by people they checked they were signed by the prescriber and in date. Associated paperwork was kept together in the tub with the medicines until final check and bagging. The dispensary team were following an updated dispensing procedure in three stages which they referred to as holistic patient centred care. So, operational safety led to medicines safety and patient safety.

At the first stage, data was entered onto the pharmacy computer and the clinical check was completed after resolving any queries such as interactions. The computer system created an electronic pharmacist information form (ePIF) and extra notes could be written on a paper PIF. Any interventions were noted on the patient medication record (PMR). The team then ordered stock and finally the prescription was dispensed. When people were collecting their prescription, the team member scanned the bag label which prompted any actions required such as counselling. This updated system had replaced the coloured laminated cards previously in use except for prescriptions for children and a 'refer to

pharmacist' card. The team initialled dispensing labels to identify who dispensed and checked the medicines for walk-in prescriptions and when the quantities of medicines had been altered. For other prescriptions an audit trail was created when team members logged into the pharmacy computer system which logged out automatically after a set length of time. The team members initialled prescriptions to show who dispensed, checked and handed out medicines.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed since the last visit. Members of the pharmacy team had trained in SOPs relevant to their role. And their roles and responsibilities were documented in the SOP folder. One member of the team explained how they verified someone's identity before handing out prescription medicines. And a member of the team explained the sales protocol for selling pharmacy only (P) medicines. The pharmacy's head office monitored training completed in the SOPs. Members of the pharmacy team understood what they could and could not do, what they were responsible for and when to seek help. A team member explained that prescriptions would not be given out or P medicines sold if the pharmacist was not on the pharmacy's premises. The most recent SOP was about providing the flu vaccination service. The pharmacy had a complaints procedure and people using the pharmacy could provide feedback via different methods.

The pharmacy's head office produced regular bulletins with patient safety information and pharmacy news. The pharmacy completed risk assessments (RAs) for the services it provided such as flu vaccination service and the NHS Pharmacy First Service (PFS) to make sure it complied with NHS requirements. Members of the pharmacy team had liaised with local surgeries. The pharmacy team had completed clinical audits required by the pharmacy quality scheme (PQS) and a clinical audit of people taking valproates. They were aware of the new rules for dispensing valproates and supplying them in original packaging. And that guidance applied to topiramate too.

The pharmacy displayed a notice that told people who the 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 maintained controlled drug (CD) registers, kept the entries up to date and checked the stock levels recorded in the registers weekly in line with the CD SOPs. The pharmacy kept records for the supplies it made by private prescription and of unlicensed specials medicines. It also maintained records of urgent supplies of medicines on PharmOutcomes.

The pharmacy was registered with the Information Commissioner's Office. Its team had completed information governance training and made 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 filed and the team had completed safeguarding training. The RP had undertaken level 3 safeguarding and the rest of the team were level 2. 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. And they described an incident involving safeguarding a vulnerable person who attended the pharmacy. The team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. The pharmacy supports and develops team members with ongoing learning relevant to their roles and keeps their skills and knowledge up to date. They are able to provide feedback about how they can improve the pharmacy's services.

Inspector's evidence

At the time of the visit, the pharmacist was supported by a registered pharmacy technician, a trainee apprentice and pharmacy technician, three pharmacy assistants (PAs) who were accredited or in training, and one person greeting people at the entrance. PAs were trained to dispense and sell medicines over the counter (OTC). The pharmacy team members covered each other's absences when needed but tried to limit how many people were on annual leave together. The pharmacy team followed a rota for breaks.

The pharmacy team members were provided ongoing training and they could access training topics such as the SOPs relevant to their role. The pharmacy's head office maintained training records for members of the team. They had protected learning time to complete accredited training. Members of the team worked well together to serve people quickly and process their prescriptions safely. The pharmacy had an OTC sales procedure for members of the team to follow when people were buying medicines. They knew when to refer requests to a pharmacist. The pharmacists were trained to deliver the PFS included triaging for when people presented with symptoms and they were able to recommend treatment or signpost them elsewhere. The team had regular appraisals with the store manager to monitor training needs. Team members had a regular huddle to plan and allocate the workload for the day. They communicated via WhatsApp groups. Team members could provide feedback and had suggested an improved way of downloading prescriptions and ordering stock. The pharmacy also had a whistle-blowing policy.

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 warm. The public area of the pharmacy was much larger in area than the dispensary and there were chairs for people who were waiting. The medicines counter and the dispensary were both on the same level at the back of the retail area and people could access the consultation room which protected their privacy. There was information in a folder explaining how to deal with needlestick injury and fainting. The pharmacy had health information on display. Members of the pharmacy team cleaned and tidied the pharmacy’s premises and records were maintained of cleaning routines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team makes sure pharmacy services are easily accessible to people with a range of needs. And its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources so they are fit for purpose. Pharmacy team members are alerted to prescriptions for high-risk medicines so they make sure people get the information they need to use their medicines safely. They store medicines securely at the right temperature and they keep records of regular checks to show medicines are safe to use. The team knows what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had a wide entrance with an automatic door and it was level with the outside walkway in the shopping centre. This made it easier for someone who used a wheelchair, to enter the pharmacy. The pharmacy team members tried to make sure people could use the pharmacy's services. They could print large font labels so they were easier to read and there was a hearing loop to help people with difficulty hearing. Opening hours were displayed along with services available.

Team members could speak or understand Bengali, Gujarati, Hindi, Urdu, Arabic, Swahili and Spanish to help people whose first language was not English. Members of the pharmacy team signposted people to another provider if a service was not available at the pharmacy. Members of the pharmacy team were prompted about prescriptions with high-risk medicines when they scanned the barcode on the bag label before giving out to people and they provided counselling on the best way to take the medicine and any monitoring information such as blood tests was recorded on the patient medication record. The RP described the prescription requirements for isotretinoin. The team members were aware of the updated rules for dispensing and supplying a valproate. For instance, initiating treatment and follow-ups with the prescriber, and supplying the valproate in its original container.

The pharmacy had a PFS referral guide on display for team members to refer to and there were SOPs to support the service. The pharmacy provided all areas of treatment for the PFS but the most requested was urinary tract infection treatment. Records were maintained on PharmOutcomes. The team had liaised with local surgeries to promote the service. People who did not meet inclusion criteria were signposted to their GP or A&E. The pharmacy had delivered the seasonal flu vaccination services. The RP described how the vaccines were stored and referred to a guide to picking the correct vaccine. The service specification and SOP were signed in the relevant places and records were kept of cleaning routines. Records for people who had the NHS flu vaccinations were entered onto PharmOutcomes. The pharmacists offered the new medicine service (NMS) to people to help them take their new medicines in the best way. The pharmacy computer flagged up new medicines prescribed for people. The pharmacists 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. All information was recorded online.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging and marked liquid medicines with a date of opening. The pharmacy team kept the dispensary benches clear as they bagged and stored completed

prescriptions and put the medicines order away. They checked the expiry dates of all medicines stock according to a matrix. In a random check no date-expired medicines were found. The pharmacy stored its stock which needed to be refrigerated in fridges 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 waste medicines. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. Records were maintained and filed; any affected stock was quarantined. People who had been supplied affected batches could be identified on the pharmacy computer and contacted.

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 marked glass measures to measure different liquids. It stored pharmaceutical stock requiring refrigeration in a medical fridge. The RP checked and recorded the maximum and minimum temperatures of the fridge at the start of the day. The blood pressure monitor was replaced regularly. The electrical equipment was portable appliance tested (PAT). There were clinical waste bins. The pharmacy had appropriate equipment such as an otoscope to provide the PFS. Confidential wastepaper was disposed of securely. 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.