

Registered pharmacy inspection report

Pharmacy Name: Boots, 10 Falcon Lane, Clapham, LONDON, SW11
2LG

Pharmacy reference: 1081173

Type of pharmacy: Community

Date of inspection: 09/11/2023

Pharmacy context

This NHS community pharmacy is set in a large retail unit near Clapham Junction railway station. The pharmacy is part of a large chain of pharmacies. It opens seven days a week. It dispenses people's prescriptions. And it sells medicines over the counter. The pharmacy delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get their flu jabs from the pharmacy too.

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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had computerised standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and complete training on the SOPs relevant to their roles to show they understood them and agreed to follow them. And they knew what they could and couldn't do, what they were responsible for and when they might seek help. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed, reviewed and recorded the mistakes it made to learn from them, and help stop the same sort of things happening again. And, for example, it strengthened its dispensing process to make sure people got the right number of tablets.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. It had a leaflet which asked people to share their views and make suggestions about how the pharmacy could do things better. And, for example, following feedback the pharmacy team tried to give people a realistic time for when they could collect their prescription. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were generally checked as often as the SOPs asked them to be. But the details of where a CD came from weren't always completed in full. And correctional notes were sometimes undated. The pharmacy largely kept adequate records to show which pharmacist was the RP and when. But occasionally a pharmacist forgot to make an entry. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it recorded when it received one of these products. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly. And the details of the prescriber were incorrect in some of the private prescription records seen. The RP gave an assurance that these records would be maintained as they should be.

People using the pharmacy couldn't generally see other people's personal information. The company

that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy had policies on information governance and safeguarding. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. Members of the pharmacy team were required to complete training on data protection and safeguarding. They knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. And the pharmacy's consulting room could be used by someone if they felt they were in danger.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has just enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of a pharmacist (the RP), a trainee pharmacy technician, and three trainee pharmacy advisors. The pharmacy had an opening for a pharmacy advisor as well as a part-time pharmacist. It depended upon relief or locum pharmacists, its team, the store management team and colleagues from other branches to cover absences. But at the time of the inspection only the RP and a trainee pharmacy advisor were working. This meant that queues could develop quickly at both the pharmacy counter and the prescription reception desk when the pharmacy was busy. And the pharmacy could do more to make sure it had enough of the right team members working at the right time and encourage people using its services to form one queue. Members of the pharmacy team didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they were nearly up to date with their workload. But they sometimes didn't have time to do all the things they were expected to do. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The trainee pharmacy advisor described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. People working at the pharmacy needed to complete mandatory training during their employment. They were also required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were kept up to date when the pharmacy wasn't busy. They were encouraged to complete training while they were at work. But they could choose to train in their own time. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to changes to the way they handed out people's prescriptions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver its services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was set in a large Boots store. Its registered area consisted of a consulting room, two counters, a dispensary and several bays of back wall shelving. And the premises were air-conditioned, bright and adequately presented. The pharmacy had some hand sanitisers and a supply of hot and cold water. Its team and a cleaning contractor were responsible for keeping its premises clean and tidy. But the sink in the dispensary was showing signs of wear. The pharmacy generally had the workbench and storage space it needed for its current workload. But its worksurfaces and floor could become cluttered when it was busy. The pharmacy had a consulting room for the services it offered that required one or if someone needed to speak to a team member in private. The consulting room could be locked when it wasn't being used to make sure its contents were kept secure. And people's conversations in it couldn't be overheard outside of it.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it largely stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The store had a small car park people could use. It had an automatic door. Its entrance was level with the outside pavement. And the area leading to the pharmacy was kept clear. These things made it easier for people to access the pharmacy and its services. But the pharmacy had reduced its opening hours since its last inspection. The pharmacy had some notices that told people about its products and the services it delivered. And it had a small seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a winter flu jab service. It had the anaphylaxis resources it needed for its vaccination service. And the pharmacist providing the service was appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used plastic containers to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They scanned the bar code of the medication they selected to check they had chosen the right product. They routinely provided patient information leaflets with the medicines they dispensed. And assembled prescriptions were not handed out until they were checked by an appropriately trained person. The pharmacy kept a record of the people involved in making up a person's prescription. It used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder cards and notes to alert its team when these items needed to be added or if extra counselling was needed. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the new rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it needed to keep its medicines and medical devices within their original manufacturer's packaging. But a few medicines

weren't. This meant the pharmacy team may not have all the information it needed if a particular make of medicine was recalled. Members of the pharmacy team marked the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have a pharmaceutical waste bin for any hazardous waste that was returned to it. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And the RP described the actions they took and what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on most days the pharmacy was open. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And steps were taken to make sure people's NHS smartcards weren't used when they weren't working.

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.