General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 128 The Chimes Shopping Centre, High Street, UXBRIDGE, Middlesex, UB8 1GA

Pharmacy reference: 1085395

Type of pharmacy: Community

Date of inspection: 22/06/2022

Pharmacy context

This is a community pharmacy in a large branch of Boots. The Boots store is in a shopping mall in the centre of Uxbridge. The pharmacy provides a range of services including dispensing prescriptions for people at home and for people living in residential and care homes. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a medicines delivery service, a COVID-19 vaccination service and a travel vaccination service.

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 has suitable procedures to identify and manage risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team keeps people's private information safe. And it knows how to protect the safety of vulnerable people

Inspector's evidence

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had put screens up at its medicines counter and at its prescription reception counter. And it had hand sanitiser for the team to use. Team members had access to personal protective equipment in the form of gloves and masks and wore masks when external visitors came into the pharmacy. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points daily. The regular pharmacist explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. And it had also had staff shortages. But it had worked with its neighbouring branch close-by. And when necessary, staff from the other branch worked at this pharmacy and vice-versa. The pharmacy had reduced its range of services during the pandemic. It had done this in part because of a lack of demand and also to concentrate on delivering a safe dispensing service and a COVID-19 vaccination service. But since restrictions had lifted it had been able to offer more of its other services. The regular pharmacist had a travel vaccination consultation with someone during the inspection.

The team had a system for recording its mistakes. It recorded them electronically and reviewed them monthly in its patient safety review meetings. The responsible pharmacist (RP) was a Boots relief pharmacist who had worked at the pharmacy several times before. She described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. This enabled them to reflect and learn. The RP team recognised the importance of monitoring and reviewing near misses and errors so that the team could learn as much as possible from them. The team agreed that records should reflect what the team member had learned and what could be done differently next time to prevent mistakes and promote continued improvement. The pharmacy also received a regular monthly newsletter from the superintendent. The newsletter highlighted areas of risk. And each month it identified common errors and ways to prevent them. It also provided educational information on a specific treatment or condition. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were up to date. And team members had read the SOPs relevant to their roles. They appeared to understand their roles and responsibilities and were seen consulting the pharmacists when they needed their advice and expertise. The RP had placed her RP notice on display where it could be seen by people. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. Each till receipt had information on the back on how people could report their experience of how they had been treated at the pharmacy. People could also give feedback directly to team members. Recent customer comments indicated that some people preferred a separate queue for handing prescriptions in and for collecting. But sometimes people continued to join a single queue. So when team members saw queues developing, they asked people who was handing a prescription in and who was waiting to collect on. So, they didn't have to queue any longer than necessary. The team had also reviewed its procedures for handing out prescriptions to ensure that one hand out was completed before another began.

The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But customer concerns were generally dealt with at the time by the pharmacists or by the store manager or deputy manager as appropriate. The store manager was as also a pharmacy adviser, and the deputy manager was a trainee pharmacy adviser. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record, its private prescription records and its records for emergency supplies. It had a CD destruction register for patient-returned medicines. The inspector and regular pharmacist agreed that it was important to ensure that the record was up to date with all patient returns recorded as soon as possible. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. Confidential paper waste was discarded into separate waste bins. And it was collected periodically to be destroyed appropriately. People’s personal information, including their prescription details, were kept out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to one of the pharmacists. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours and found two pharmacists on duty. The regular pharmacist was present along with a Boots employed relief pharmacist who had worked at the pharmacy several times before. The relief pharmacist was the RP for the day. Pharmacists worked alongside a dispensing assistant, two trainee PAs and a healthcare assistant. One of the trainee PAs worked in the dispensary and the other was putting stock out on the shop floor in between helping her colleague HCA on the counter. The store manager PA and the deputy manager trainee PA were present in the pharmacy for the inspection. But could be available to help in the pharmacy when it was very busy. Overall, team members were seen to work effectively with one another. The pharmacy had a small team who worked regularly together. The daily workload of prescriptions was in hand and customers were generally attended to promptly. Pharmacists were generally able to make day-to-day professional decisions in the interest of patients.

Team members could discuss their concerns with their line managers. And they felt supported in their work. They had regular reviews about their work performance. And they kept their knowledge up to date through regular online e-learning training modules. Each member of the team was allocated an hour of training time each week. If they had been unable to take it one week, they would be allocated double the training time the next week. Pharmacists could make their own professional decisions in the interest of people and did not feel under pressure to meet business or professional targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help reduce the risk of the spread of viral infections. And its workspace is tidy and organised.

Inspector's evidence

The Boots store occupied two floors. And the pharmacy was at street level on the lower floor. The store had two entrances on the lower floor. One from the shopping mall and one from the high street. And it had a third entrance on the upper floor from the mall. The pharmacy had set up a COVID-19 vaccination hub in the middle of the lower floor near the high street entrance close to the main pharmacy area. The vaccination hub was separated from the rest of the retail space by screens. The hub had a mobile reception pod, a waiting area, four vaccination stations and an administration desk. It also had an observation area for people to sit post vaccination if necessary. People attending for a vaccination followed a one-way system through the hub.

The pharmacy had a long pharmacy counter running alongside the dispensary and a small waiting area. It kept its pharmacy medicines behind the counter. The dispensary had a countertop where people could hand in or collect their prescriptions. The pharmacists' checking area was on a countertop below this. Screens along the reception counter prevented people from seeing prescriptions on the checking area. The dispensary had workbenches along two sides with storage areas above and below. And it also had a carousel in the middle for storing many of its more frequently used items. Dispensed items and prescriptions were stored so that people's information was generally kept out of view. The pharmacy also had a consultation room. The consultation room was close to the counter and dispensary. It was located at the edge of the shop floor. And it was locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that its services are supplied safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly.

Inspector's evidence

All three of the pharmacy's entrances provided step-free access. And people could access the pharmacy and the vaccination hub from any of its entrances. At the time of the inspection the vaccination service was provided two days per week. This was because demand had dropped since the height of the pandemic when the service was provided most days each week. The pharmacy had retained the hub expecting that demand may increase again when the winter season approached. The vaccination hub was managed by a separate team of staff to those delivering the pharmacy's day-to-day services. So that it did not interfere with them. The pharmacy's customer area was free of clutter and unnecessary obstacles. And it had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions if required.

The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy sent many of its regular repeat prescriptions to a Boots centralised dispensing hub known as a dispensing support pharmacy (DSP). Prescriptions were dispensed at the DSP hub using an automated dispensing system before being checked and bagged. They were then delivered back to the pharmacy in sealed bags for collection or delivery. The system was designed to free up pharmacists' time in-store, so that they could provide other services, manage walk-in and acute prescriptions and multi-compartment compliance pack dispensing. The pharmacy also supplied medicines against private prescriptions, many of which came from its online prescribing service. The prescribing service used both medical and pharmacist independent prescribers.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The pharmacy managed the service according to a four-week rota. Each month any changes to prescriptions were checked and verified. And people's records updated. The pharmacy also had a system for managing any changes made to people's prescriptions within the monthly cycle. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, and with regular repeat medicines. So that people had the information they needed about their medicines. The pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. Both pharmacists were aware of the precautions they would need to take, and counselling they would give, if it were to be prescribed

for someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It stored its medicines appropriately and in their original containers. And the stock on its shelves was tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. A random sample of stock checked by the inspector was in date. Short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. Its equipment was generally clean. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room, vaccination hub and the dispensary. Computers were password protected. Team members had their own smart cards but occasionally they used each other's. The inspector and pharmacists agreed that people should use their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.