General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 7A, Greenwich Shopping Park, Bugsbys Way, LONDON, SE7 7SR

Pharmacy reference: 1088343

Type of pharmacy: Community

Date of inspection: 07/06/2023

Pharmacy context

This pharmacy is situated in a retail park and is open extended hours. As well as dispensing NHS prescriptions, the pharmacy provides a number of private services including a cystitis treatment service. It also provides seasonal flu vaccinations, the New Medicine Service (NMS) and Community Pharmacist Consultation 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 appropriately identifies and manages the risks associated with its services. And team members work to written procedures to help them provide the services safely. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce future risk. It protects people's personal information well. And team members understand their role in protecting vulnerable people. The pharmacy keeps the records it needs to by law, to help show that it supplies its medicines safely and legally.

Inspector's evidence

Standard operating procedures (SOPs) were available and were up to date. Most SOPs were available digitally. Team members completed training about the SOPs online. All team members had completed the SOP training required for their roles. Hard copies of SOPs were also available. The store manager was able to check what training team members had completed.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded electronically as they occurred. And each month a patient safety review was completed after which the team members were briefed on the findings and next steps. Since the responsible pharmacist (RP) had joined the team, she had made it a priority to ensure all near misses were communicated to team members. Dispensing errors were reported online. Team members explained that there had not been a dispensing error for a while and were able to describe the process they would follow if one happened.

The pharmacy team received a monthly Professional Standards bulletin from the superintendent's office. This also covered learning from errors and included case studies. Team members were all required to read through this and sign once they had done so.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. It had a complaints procedure, and the store manager informed the team of complaints received. The team tried to resolve these in store where possible. Where matters could not be resolved these were then escalated. People were also given feedback cards which they could use to provide feedback online.

Records for private prescriptions, emergency supplies, RP records and controlled drug (CD) registers were well maintained. The pharmacy did not dispense many unlicensed medicines; team members were able to describe the records they would keep. CDs that people had returned were recorded in a register as they were received. CD balance checks were completed at regular intervals.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in a way to ensure people's private information was out of sight of the public. Team members all completed mandatory annual training about information governance and had read the relevant SOPs. Team members who needed to access NHS systems had individual smartcards. The RP had access to Summary Care Records and consent to access these was gained from people verbally. Confidential

waste was separated into designated bags and sent to head office for destruction.

Pharmacists had completed level two safeguarding training and other team members had completed the Boots mandatory training about safeguarding, electronically. The RP was unsure if details for local safeguarding boards were available and the NHS safeguarding application was discussed. Team members would refer any concerns to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides, and they work effectively together and are supportive of one another. They have the appropriate skills and qualifications or are completing the right training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the RP who was the regular store-based pharmacist and who had started working at the pharmacy a few months before the inspection. A trained pharmacy advisor worked five days and covered both the counter and dispensary. The pharmacy had other pharmacists who covered the weekend shift. The assistant manager was a trained dispenser and helped when needed. The RP said the workload was manageable.

Locum pharmacists covered the shift from 6pm until midnight. The store closed at 8pm after which people using the pharmacy were served via a hatch. In the morning, people were served via the hatch between 8am and 9am when the store opened. To help manage the workload some dispensed prescriptions were left for the locum pharmacists to check in the evening when it was generally quieter. Team members said the team worked well together.

The pharmacy advisor was observed counselling people on the use of over-the-counter medicines and asking appropriate questions before recommending treatment. She would refer to the pharmacist if she was unsure. She was aware of the maximum quantities of medicines that could be sold. To keep up to date, team members completed ongoing training; some of this was accessed through the e-learning platform. Digital records were kept and progress on completion was monitored by the store manager. E-learning modules included mandatory training on health and safety, safeguarding and information governance. Team members were provided with time to complete training in store. Professional standards bulletins were received from the superintendent's office. This was read and discussed between the team. Team members were in the process of re-reading SOPs as these were being moved onto an electronic format. Representatives from various manufacturers also visited to provide information about new products.

Staff performance was managed by the store manager who carried out reviews with all team members. The RP and dispenser provided each other with feedback. As the team was small, they discussed issues as they arose. The store manager provided the team with a weekly performance update and the team discussed how they could improve where needed. The RP provided locum pharmacists with a handover and there was a communication book. The team also used a group chat on a messaging application to share information. Team members felt able to provide the store manager and area manager with feedback. The company also had an internal platform which could be used to share feedback. Targets were set for the services provided, however team members said whilst there was some pressure to meet the targets, this did not affect their professional judgment.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean; there was ample workspace which was clear and tidy and was allocated for certain tasks. There were designated areas for storing prescriptions waiting for an accuracy check and the shelves were clearly labelled. Medicines were stored on shelves in a tidy and organised manner. A clean sink was available in the dispensary. A contracted cleaner cleaned the floors daily and team members did the rest of the cleaning. The room temperature and lighting were adequate for the provision of healthcare. The pharmacy was kept secure from unauthorised access.

A clean, signposted consultation room was available. This was easily accessible. The room was small and did not have a ceiling. The RP said she spoke quietly whilst in the room to ensure conversations could not be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It takes steps to help ensure that people with a range of needs can easily access the pharmacy's services. It obtains its medicines from reputable sources, and it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was easily accessible with a flat, step-free entrance from the car park. The shop was all located over one floor and aisles were wide and clear with easy access to the pharmacy counter. A hearing loop was also available, and the pharmacy had the ability to produce large print labels. Some team members were multilingual, or the team used translation applications. People were signposted to other services were appropriate. Team members had knowledge of the local area and also used NHS websites. People were most commonly signposted to sexual health clinics.

The RP felt NMS benefitted local people the most. The service ensured that people were getting the best out of their medicines. And provided them with the ability to raise any issues in a private and confidential space. It also allowed the RP to refer any issues back to the GP. The RP gave an example of someone who had been started on a medication for their blood pressure which led them to have bad headaches and swelling. The RP had contacted the person's GP and their medication had been changed.

Most prescriptions were received electronically by the pharmacy. Prescriptions for antibiotics and acute medicines such as anti-inflammatories were processed and dispensed straight away. Other prescriptions were entered onto the system and stock was ordered. If there was a stock availability issue, the person was informed, and they were given the option of trying other pharmacies or referred back to their GP. Once the stock was received the labels were printed and medicines dispensed. The labelling system required barcodes from the medicine packs to be scanned for the label to be generated. Prescriptions were dispensed by the dispenser and checked by the RP. Dispensing audit trails were maintained. Team members signed the quadrant stamps printed on the prescriptions forms to identify who was responsible for dispensing, accuracy checking, clinical checking and handing the prescription out. Dispensed and checked by boxes were also available on the labels which were used by all team members. Plastic tubs were used to separate prescriptions to prevent transfer between patients.

Pharmacist Information Forms (PIFs) were used to highlight any clinical issues or changes to the prescriptions as well as counselling advice that needed to be passed on. These were printed automatically when labelling; hard copies were also available for team members to handwrite any additional notes. Team members used laminate cards to highlight prescriptions for CDs, fridge lines, and for medicines such as methotrexate, lithium and warfarin. These cards had question prompts on the back for information to check with the patient. Other laminates were available for 'refer to pharmacist' and paediatric prescriptions. Team members also highlighted any unusual doses, if medicines were out of stock or if there was a manufacturing issue.

Team members and the RP were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). At the point of dispensing the dispenser checked if the person fell into the at-risk group. A laminate was placed with the prescription and the PIF was highlighted. Packs of sodium valproate were not split, and the dispenser was aware of where to place the label on the pack. The team had read the SOPs and looked at alerts. People in the at-risk group who were not part of a PPP would be referred to their prescriber. The pharmacy did not have anyone who collected sodium valproate and who was in the at-risk group.

Additional checks were carried out when people collected medicines which required ongoing monitoring. For medicines such as methotrexate and warfarin a specific laminate was attached to the prescription which prompted team members about the checks they were required to complete. The company also had specific SOPs on dispensing and supplying these medicines. The pharmacist described the checks that would be carried out, but the information was not recorded on the person's electronic record unless they mentioned something of concern. When dispensing methotrexate, the dispenser checked to ensure it was a weekly dose. And when writing out the dosage on the labels she ensured that the number of tablets to be taken was written in words.

In date patient group directions (PGDs) were available for the services provided. The cystitis service was the only service available under a PGD at the time of the inspection. The RP had completed all the accreditation for the service but had not signed the PGD. She provided an assurance that she had not provided the service since she had joined and would ensure the PGD document was signed. Pharmacists were required to complete online training as part of the accreditation and had face-to-face training for the vaccination training which included anaphylaxis.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. Date checking was done routinely with a section checked each week. No date-expired medicines were seen on the shelves checked. A date-checking matrix was available. Short-dated stock was labelled, and a record was also made. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors.

Drug recalls were received electronically from head office on the computer system, the system was checked twice a day. The store manager usually printed out any pharmacy related recalls and handed them to the team members who took the required action. Once the actions had been taken, team members were required to update the system and the hard copies were filed in the dispensary.

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 glass, crown-stamped measures, and tablet counting equipment. Equipment was clean and ready for use. Separate labelled measures were available for measuring liquid CD preparations to avoid cross-contamination. The pharmacy had a medical grade fridge and a legally compliant CD cabinet. Up-to-date reference sources were available including access to the internet. Computers were all password protected and screens faced away from people using the pharmacy.

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.