General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Westfield London Shopping Centre, Ariel Way, London, W12 7HT

Pharmacy reference: 9010862

Type of pharmacy: Community

Date of inspection: 12/06/2023

Pharmacy context

The pharmacy is located within the Westfield shopping centre and is open extended hours over seven days. It dispenses NHS prescriptions and provides NHS funded services such as the New Medicine Service (NMS). Private services are also available and these include travel vaccinations and chicken pox 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	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 adequately manages its risks to make sure its services are safe. Team members discuss and learn from any mistakes they make. And they are clear about their roles and responsibilities to help make sure they provide services safely. Team members keep people's private information secure and they know how to help protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in the dispensary. The superintendent's team at head office updated the SOPs periodically. All current members of the team had signed the SOPs to confirm they had read and understood them. They also had an online portal which enabled the store manager to see the training team members had completed.

The SOPs defined the team members' roles and responsibilities. Team members could explain their main responsibilities and worked within their capabilities. Staff wore uniforms and name badges and so were easily identifiable. The responsible pharmacist (RP) notice was visible from the retail area and identified the pharmacist on duty. The pharmacy team members knew clearly what they could and couldn't do in the absence of the RP.

The pharmacy team members highlighted and recorded mistakes made during the dispensing process. This included mistakes which had been identified before the medicine had been handed to a person (near misses). And those where a mistake had happened, and the medicine had been handed to a person (dispensing error). The pharmacy had documented evidence of regular near misses recorded on the online reporting tool. The assistant manager discussed learning points from errors and how to prevent them from happening again with individual members of the team. The team recently investigated why incorrect quantities of medication had been dispensed on several occasions. The pharmacy had put extra measures in place such as having regular discussions with the team members, circling odd quantities on the prescription and highlighting the quantity on dispensing labels. Each month, the pharmacy manager discussed information shared by the company about incidents that had occurred nationally, with each team member. This was to learn from these events at a local level. The report was also shared with the team members to view and refer to at any time during the month.

The pharmacy had a documented procedure to manage complaints and for reporting. The pharmacy team members clearly understood how to deal with people's feedback. There was also a notice to inform people how to provide feedback or complain. Team members described how they would try and resolve the complaint and if they couldn't do so in the pharmacy, they would signpost people by giving them the head office contact details. If the pharmacy received negative feedback, the store manager shared it with the whole team to try and learn from it. And if an individual received positive feedback, this was also shared with the team. The pharmacy team members could not give any examples of changes made in response to people's feedback.

The pharmacy had up-to-date professional indemnity insurance. The pharmacy team maintained appropriate records including controlled drug (CD) registers, responsible pharmacist (RP) records and private prescription records. The pharmacy kept running balances in all the CD registers, and these

were audited against the physical stock on a regular basis. The inspector checked the running balances against the physical stock at random for three products and they were all correct. Records about private prescriptions and emergency supplies were held electronically in date order. The pharmacy filed unlicensed medicine invoices in a designated folder, but some records did not contain information about when the medicines had been supplied to the person.

The pharmacy had information governance policies. The pharmacy team members understood the principles of data protection and confidentiality. The pharmacy stored confidential information securely and separated confidential waste prior to collection and disposal by a licensed contractor. The pharmacist had completed level 2 safeguarding training and team members had completed company safeguarding modules. Details of local support agencies were not available, but team members knew how to access this information should they need it. The pharmacy had a chaperone policy and the team members were aware this was an option which could be offered to people. The pharmacy team members knew how to report concerns and were aware of safe space initiatives such as 'Ask ANI'. A consultation room was available and pharmacy team members were aware this was an option which could be offered to people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together in a busy environment to manage the workload. They have the right qualifications and training for the jobs they do and are comfortable sharing ideas and concerns.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were three pharmacists (one of whom was the RP), the store manager, assistant store manager, a dispenser and three trainee dispensers. The store manager and assistant manager were also trained dispensers so could help when needed. The RP felt the workload was manageable and the team was observed managing the workload well throughout the inspection. The store manager had a staff rota to make sure there was at least two members of staff during the day with the RP.

The pharmacy team members were up-to date with their training and the trainees were on track with their courses though appraisals were not being conducted. The store manager proactively checked and was alerted when anyone had outstanding modules to complete and allowed the team member to complete any learning during working hours. The pharmacist employed to do services had records of training to be able to deliver these including travel vaccinations, pneumonia vaccinations, cystitis treatment via PGD and flu vaccinations.

Regular huddles occurred to communicate the latest and relevant information. As it wasn't always possible to have a team meeting with everyone present, the assistant manager spoke to every team member individually. There was a notice board upstairs in the dispensary where important messages were communicated. Team members were happy to raise any concerns and comfortable sharing ideas with the store manager. The team members provided positive feedback about the working environment and about the store manager. They felt listened to and said how supportive the store manager was. The store manager equally felt well supported by the area manager. The pharmacy did have targets in place, but team members did not feel they were pressured in achieving them. The pharmacist also commented that she had a target to do a certain number of services but didn't feel pressured if she didn't hit the target. Furthermore, she was in control of her diary and had enough time to spend with people. The team members were aware of the whistleblowing policy and knew what to do in the event of needing to raise a concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy premises were clean, organised and maintained to a suitable standard. The pharmacy was accessible for wheelchair users and the passageways were generally free of clutter and obstruction. There was enough space to carry out dispensing tasks safely. The dispensary, benches and prescription storage areas were reasonably well-organised. The pharmacy had two clean signposted consultation rooms available, and these were kept locked when not in use. The rooms had enough space and private conversations in them couldn't be heard from outside. There was no confidential information accessible.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and had hot and cold running water. Cleaning was carried out by an external company and by the team members. Room temperature was controllable, and levels of ventilation and lighting were appropriate during the visit. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages and delivers its services safely and effectively. It gets its medicines from reputable suppliers, and it stores them securely. Team members identify people receiving higher-risk medicines and carry out appropriate checks. And they provide these people with relevant information so they can take their medicines safely.

Inspector's evidence

The shopping centre and pharmacy were easy for people to access, including people who were wheelchair users or had mobility aids. A hearing loop was available in the dispensary and team members explained how, if they needed to, they would action specific requests for people such as producing large font labels. The pharmacy's opening hours were clearly displayed as people entered the store. The pharmacy opened for longer hours than many other pharmacies in the area, including Saturday and Sunday. Private services were popular due to the location and because of the extended opening times. The pharmacy had a stand by the counter which had many different health leaflets for people to take. Team members used local knowledge and the internet to support signposting.

Information about each of the Boots private services was available for the pharmacists to refer to. The pharmacist explained the patient journey for the travel vaccination service and for the chicken pox vaccination and the various training that she had undertaken before becoming accredited to offer the service. The store manager also gave an example of positive feedback received about the services provided by the pharmacist. Appointments were booked in advance for most services, so the pharmacist could plan their daily workload and offer more appointments when a second pharmacist was present.

The pharmacy had a clear flow of dispensing and checking. Dispensing audit trails were maintained to help identify who was involved in dispensing, checking and handing out prescriptions. Additional notes were added to the patient medication record (PMR) as appropriate. And extra warning labels on the PMR system could be printed by team members to ensure the RP had access to all the relevant information. Baskets were used during the dispensing process to isolate individual peoples' medicines and to help prevent them becoming mixed up. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And the team kept the original prescription to refer to when dispensing and checking the remaining quantities. Medicines awaiting collection were stored in drawers and patient identifiable details couldn't be seen from the shop floor. Members of the team were observed confirming people's names and addresses before handing out dispensed medicines. Medicines awaiting collection were checked regularly to help ensure people collected their medicines and to increase space. People were contacted to help remind them to collect medication.

The pharmacy team used colour-coded cards to highlight higher-risk medicines and when people needed extra counselling when they collected their prescription medicines. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme. The pharmacist explained how they counselled people accordingly when each valproate was dispensed. The RP asked people receiving warfarin for their latest blood test result each time they received a prescription for warfarin. This was to check that their results were within the expected range. People taking lithium often let the team

members know when they had their blood test and if the lithium levels were in range. Team members however didn't record this on the PMR.

The pharmacy obtained medicines from licensed wholesalers and stored them in an organised way on shelves. It kept all stock in restricted areas of the premises where necessary. The pharmacy had medicinal waste bins to store out-of-date stock and patient-returned medication. The pharmacy kept its CDs securely. It stored out-of-date and patient-returned CDs separate from in-date stock. The team members checked medicine expiry dates every week and marked medicines with a short expiry date to prompt them to check the medicine was still in date when dispensing. No out-of-date stock was found amongst the sample of medicines selected. The team members recorded the dates of opening for medicines with altered shelf-lives after opening. This meant they could assess if the medicines were still safe to use.

Pharmacy team members monitored the minimum and maximum temperatures of the medicine fridges daily. Records seen were within acceptable limits. Over-the-counter medicines were stored appropriately, and staff were aware of higher-risk over-the- counter medicines such as painkillers containing codeine. Team members asked relevant questions and referred to the RP if they had concerns. Staff were observed during the inspection only selling one packet per person and referring to the RP if a person wanted more. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the company communication portal. The store manager printed the alerts off, signed them once actioned and then stored them in a folder. There was a clear audit trail of the alerts actioned and they were all up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities to provide its services safely and to protect people's confidentiality.

Inspector's evidence

The pharmacy had a range of up-to-date references sources available, and the RP explained that she used the online BNF on her phone for ease of access and for more up-to-date information. The pharmacy had a set of clean, well-maintained measures available for measuring liquids. This included separate measures for different medicines, to help avoid cross-contamination. The pharmacy computers were password protected and access to peoples' records restricted by the NHS smart card system. The computer terminals were kept in a secure area of the pharmacy away from public view. The medicine fridges were clean and suitable for storing medicines. The pharmacy's equipment was tested regularly to make sure it was safe and functional.

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.