General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 293 Walworth Road, London, SE17 2TG

Pharmacy reference: 9011212

Type of pharmacy: Community

Date of inspection: 14/02/2022

Pharmacy context

This pharmacy is located on a busy local high street and near a market. The pharmacy serves people of all age ranges and receives most of its prescriptions electronically. It provides the New Medicine Service. It also provides medication in multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. The inspection took place during the Covid-19 pandemic.

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 generally manages its risks appropriately to make sure people are kept safe. It keeps the records it needs to by law. So, it can show that supplies are made safely and legally. Team members get training so they know how to protect vulnerable people and the pharmacy manages and protects people's confidential information appropriately.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs), which had been updated in September 2021. But team members were still in the process of reading and signing them as they had not had time due to staff shortages in the last few months.

Risk reviews were done as part of the pharmacy's weekly checks, which included reviewing pest control, fire alarms, and hazards. Patient safety reviews were carried out monthly and involved reviewing any dispensing mistakes, alerts or complaints. Dispensing mistakes which were identified before the medicine was handed to a person (near misses) were documented electronically. The RP said that this was beneficial as it reduced the likelihood of losing records, but one downside was that some members of the team found it too time consuming. The RP said that the most common dispensing mistakes identified were quantity errors. Team members had been told to dispense on the back bench to help minimise distractions, and to count the medicine twice. Some higher-risk medicines were stored separately to help minimise picking errors, for example, gliclazide and methotrexate.

Dispensing mistakes which reached people (dispensing errors) were recorded electronically and reported to the pharmacy's head office. Team members were briefed to check the bag label at the point of retrieval and when handing to the person. This had been implemented following a handout error. People were also asked to confirm their details before they left. Team members signed the bag labels signed during the dispensing and handout processes to confirm that they had checked it was the correct label.

Plastic screens had been fitted at the front counters. Personal protective equipment (PPE) and hand sanitizers were available. Only one member of staff took a break at any one time as the staff room was relatively small. There were floor markings and signage to help remind people of the safe distancing measures. Members of the team cleaned the pharmacy at least once a day and signed a log to help keep track. A staff risk assessment had been done at the start of the pandemic and team members had completed an eLearning module on infection control.

The correct responsible pharmacist (RP) notice was displayed, and the RP record was in order. The pharmacy had current professional indemnity insurance. Samples of records for the supply of unlicensed medicines, private prescription and emergency supplies were complete. Controlled drug (CD) registers were maintained in accordance with requirements. A random stock check of a random CD agreed with the recorded balance in the CD register. Expired CD stock was kept separated from in-date stock. CDs returned by people were recorded in a destruction register.

Members of the team handed out cards referring people to an online feedback form. The contact number for the pharmacy's head office was also printed on pharmacy bags for easy access. Members of

the team said they had received some feedback about the pharmacy being very busy and not having enough staff and the long waiting times. The RP said that this feedback had been shared with the area manager.

Team members had completed the company’s mandatory eLearning modules on information governance, the General Data Protection Regulation and code of conduct. A consultation room was available for private conversations and services. Computers were password protected and access to the PMR system was via individual smartcards. Confidential waste was stored in separate waste bags which were collected by head office.

All members of the team had completed the company’s annual eLearning module on safeguarding vulnerable groups. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education module about safeguarding. One dispenser said that she would read the relevant SOP and speak to the RP if she had any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just about enough staff to provide its services safely. The pharmacy team can provide feedback and concerns relating to pharmacy service. Team members undertake the right training for their roles. And they get some ongoing training. But they sometimes find it difficult to complete this training during work time, which could make it harder to for them to keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection, the pharmacy team comprised of a regular pharmacist and two qualified dispensers. Another two part-time dispensers worked at the branch but were not present during the inspection. The pharmacy was relatively busy, and queues built up at times. The team appeared very busy, and members tried to manage both the medicine counter and dispensary, as well as answering the telephone, which was constantly ringing throughout the inspection. Several people walked off after not being served in a timely manner, whilst other people were overheard querying if there were staff serving at the counter. Members of the team said that this was the norm at the branch as the pharmacy had been experiencing staffing shortages recently. A dispenser had left employment and had not been replaced. But staff said that tasks were completed in a timely manner, and the pharmacy did not have a backlog of work.

The dispenser was observed providing additional advice when selling Pharmacy-only medicines and advising people to read the patient information leaflet inside the packs. She also referred to pharmacist, for example, following a query about the dose of a prescription-only medicine.

Members of the team said it was relatively stressful at work due to the staff shortages and that it was a struggle to keep on top of the work every day. But they managed to catch up with any backlog when a third dispenser was working. They provided positive feedback about the pharmacist, who was also the store manager. Appraisals were conducted twice a year. Members of the team were happy to raise concerns to the pharmacist and said that she was open to feedback. Targets were set by head office, but the team felt that these were achievable.

Members of the team said that they kept their knowledge and skills up to date by reading the superintendent pharmacist’s monthly newsletters and completing eLearning modules as and when they could. They found it difficult to fit training during working hours due to current staffing levels, and some members could not remember the latest training they had completed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps all areas of the dispensary and consultation room clean.

Inspector's evidence

The dispensary was located at the back of the premises and was clean and organised. The pharmacy had relocated from next door and fixtures and fittings were new and generally well maintained. The flooring however was marked and required cleaning. There was sufficient work and storage space, and workbenches were generally kept tidy. The prescription drop-off and collection areas at the front counter were clearly signposted.

A hatch was fitted between the dispensary and retail area to hand over medicines discreetly. Sinks were fitted in the dispensary and consultation room to allow for hand washing and preparation of medicines. But both required cleaning.

A spacious consultation room was available for private conversations and services. The room was kept locked when not in use. There was no patient-sensitive information stored inside the room. Some empty multi-compartment compliance packs were stored uncovered outside the consultation room and near the waiting area. These were removed during the inspection. Two wipeable chairs were available for people wanting to wait for a service. A hand sanitization station was available near the front door, but it required cleaning.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services and the pharmacy provides its services safely. People taking higher-risk medicines are provided with the information they need to take their medicines safely. Medicines are well managed and appropriate action is taken where stock is not fit for purpose.

Inspector's evidence

Access into the pharmacy was step-free and through a wide double door. There was ample space in the retail area and consultation room for people with wheelchairs and pushchairs. Services were listed in the pharmacy's practice leaflet which was displayed at the front counter. Some members of the team were multilingual and were observed translating for people who did not have English as their first language. They were also observed signposting people to other providers or sources, for example, the UK government website for Covid-19 travel advice.

Dispensing audit trails were maintained to help identify who was involved in dispensing, checking and handing out a prescription. Members of the team were observed confirming peoples' names and addresses before handing out dispensed medicines.

Electronic 'Pharmacist Information Forms' (ePIFs) were generated by the patient medication record to highlight any changes to a person's medicine, allergy status, higher risk medicines, or if a person was suitable for a particular service, such as the New Medicine Service. These were seen to be attached to dispensed prescriptions.

Higher-risk medicines were flagged with coloured laminates and ePIFs. The coloured laminates listed all the relevant checks the pharmacy staff should make before supplying the medicine. Team members were aware of the valproate guidance and said they carried out checks to identify people in the at-risk group and provided them with additional advice. Valproate information cards, steroid books and steroid emergency cards were available at the pharmacy.

Prescriptions for Schedule 2, 3 and 4 CDs were marked with coloured stickers which were annotated with the expiry date of the prescription. This helped reduce the risk of supplying these medicines past the valid date on the prescription. CD instalments were dispensed in advance for the week to help minimise distractions. Clear bags were used to store dispensed fridge items and CDs. This allowed for a third check with the patient at handout.

Medicines awaiting collection were stored in drawers and were cleared on a weekly basis to reduce clutter. People were sent text messages to remind them to collect their medication before the medicines were removed from the retrieval. Removed prescriptions were retained at the pharmacy until they expired, should the person return to collect the medicine.

A 'Medisure progress log' was displayed in the dispensary and used to help keep track of prescriptions ordered for people receiving multi-compartment compliance packs. But the log was not always completed with the dates on which the various tasks were done. This may mean that the team did not have a full audit trail of when prescriptions were ordered, assembled, and supplied. Prescriptions were

cross checked with individual record sheets once they were received. The packs were dispensed on a back bench in the dispensary to help minimise distractions. The original medicine packs were retained with the assembled packs for the pharmacist to check when carrying out the final accuracy check. Medicine descriptions were provided, and patient information leaflets were routinely supplied.

Stock was obtained from reputable wholesalers and was stored tidily on the shelves. Expiry date checks were conducted on sections of the dispensary stock every week. Medicine with short expiry dates were highlighted with a coloured sticker. No out-of-date medicines were found at the time of inspection. The fridge temperatures were monitored daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were actioned, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Measuring cylinders, tablet and capsule counting equipment were clean and ready for use. A separate triangle was available and used for cytotoxic medication. Up-to-date reference sources were available including access to the internet. One fridge was available. Computers were password protected and screens faced away from people using the pharmacy. Confidential waste was collected in separate waste bags.

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.