General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 205 Station Lane, HORNCHURCH, Essex, RM12 6LL

Pharmacy reference: 1031221

Type of pharmacy: Community

Date of inspection: 11/04/2019

Pharmacy context

This is a small community pharmacy located opposite an Underground station. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance aids. It also provides flu and pneumococcal vaccinations.

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
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 identifies and manages the risks associated with its services. It largely keeps all the records it needs by law. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place and were up-to-date. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs.

Near misses were highlighted to the dispenser, and the responsible pharmacist (RP) discussed with the dispenser as to why the error may have occurred and an entry was made on the near miss log. The team were using a new log template which also allowed for reflection to be recorded. At the end of the month the patient safety champion analysed near misses and discussed findings as part of the huddle. As a result of past reviews quetiapine and olanzapine had been separated on the shelves. And 'select with care' labels had been attached to some shelf edges. The team also used stickers to highlight look alike sound alike (LASA) medicines and had highlighted Buccastem and Quinoric for one of the dispensers, who commonly made a mistake when picking these items.

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. These were also recorded on the near miss log and became the focus area for the next patient safety review. Details of incidents were shared with the team so that learning could be gained. As a result of an incident where someone had been handed out another person's medicines the team confirmed the address before attempting to look for the prescription and again at handout. Other details such as date of birth were also checked on some occasions. Notes had been made on the patient medication record where people had similar names.

The technician was the patient safety champion and on a monthly basis reviewed all recorded near misses and incidents. She said that after the analysis she would choose a focus area depending on the trend found. Previously she had focussed on inhalers and asked team members to look at the different types of inhalers available. Limited space had also been highlighted as an area of risk and colleagues were reminded to keep the dispensary tidy. The technician supported individuals if she felt that they were struggling and would try to buddy them up with another colleague.

The pharmacy had a complaints procedure in place and details of the customer care team were printed at the back of the receipts. Annual patient satisfaction surveys were also carried out. The team also handed out patient survey cards which could be completed online at any time with feedback sent to head office. Following feedback, the pharmacist had reviewed the process by way in which repeat Viagra Connect could be sold to a customer's female representative. The team also made people aware of the availability of the consultation room.

The correct RP notice was displayed; however, this was not clearly visible from the medicines counter. The store manager said that she would move this following the inspection. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Professional Indemnity insurance was in place.

Records for private prescriptions, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. Records for emergency supplies were generally well maintained but one of the entries observed did not have a reason for supply recorded.

CD balance checks were carried out on a weekly basis. A random check of CD medicines complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored on a retrieval system and were not visible to people. An information governance policy was in place and each year the team were required to complete training on the E-Learning system. The team had also completed an E-learning module on the General Data Protection Regulation. Members of the team who worked in the dispensary had their own smartcards. The store manager was in the process of setting up access to Summary Care Records.

The team had completed safeguarding training on the E-learning system; in addition to this the RP had also completed the level 2 training. Details for the local safeguarding boards were available and the team could describe where this could be found. The team would report any concerns to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy well and team members work well together. The team members work within their level of competence. They are given the appropriate training to deliver the pharmacy's services safely.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the store manager (regular pharmacist), a technician and two dispensers. Once every one or two weeks the pharmacy had an extra pharmacist to provide support, she was present on the day of the inspection and also covered the pharmacist's days off. Saturdays were covered by one of the team members who would have half a day off in the week. The store manager said that there were enough team members for the services provided.

Staff performance was managed formally with reviews carried out every six months. The half year review was less formal than the end of year review. The store manager also gave the team on the spot feedback.

The dispenser counselled patients on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine and would always refer to the pharmacist if unsure.

The team were provided with regular training modules on E-learning which covered a range of different topics and areas. In addition to this each month the team were sent '30-minute tutors' which covered different over-the-counter conditions or products. The team members could take time in store to complete their training since the new store manager had started. The technician said that she also did independent reading to learn about new drugs etc. In her previous store the store manager was involved in training relief pharmacists so had experience of training people.

The relief pharmacist's line manager supported her with ongoing training and she discussed things with pharmacists in other stores. The pharmacy team received communication from head office electronically on Boots Live (the company intranet) as well as receiving communication on a weekly basis in the manager's bags.

Pharmacists also had access to Pharmacy Unscripted which had resources available for training and revalidation. Let's Connect events were attended by the pharmacists and technicians so that they could share learning with teams in other stores.

The store manager and team members felt able to give feedback; team members usually spoke to the technician who would then pass on matters to the store manager. The team had also recently completed a colleague survey. The relief pharmacist said that she learnt different things from different stores, and teams were usually receptive to ideas. The manager of the store usually asked her how she had found the day.

Targets were in place for the services provided and the store had a target to deliver 400 medicine use reviews (MURs) each year. The team said that there was no pressure to meet the targets. The store

manager said that it was her ambition to provide the best service. The relief pharmacist said that she updated her line manager with the number of services that she had provided. She said that the store team would usually tell her what they wanted her to do.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and a suitable place to provide healthcare.

Inspector's evidence

The pharmacy was in the main clean and suitable for the provision of healthcare. However, the dispensary was small and had limited workbench space available. Workbench space had been roughly allocated and the team tried to keep dispensing and checking areas clean. The RP said that due to the limited space things could get messy. Multi-compartment compliance packs were prepared in the consultation room. These had previously been prepared in the dispensary but the number of people on this service had significantly increased in the past few years. Cleaning was done by the team with a rota in place. Medicines were arranged on shelves, the team tried to keep this tidy and organised. A clean sink was available but this was aged.

A signposted consultation room was available. This was easily accessible from the shop floor. The door to the room could not be locked. A dispenser was working in the room preparing multi-compartment compliance packs and there were a number of baskets with prescriptions and prescription only medicines. The RP said that due to holidays the dispenser was working on a number of packs but usually only had one basket in the room at a time, which she would take out with her if she had to leave the room or if the room needed to be used. As there was more than one basket present in the room on the day of the visit the dispenser was making sure that the room was not left unattended.

The premises were kept secure from unauthorised access.

The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to help regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It gets its medicines from reputable sources and generally manages them well. The pharmacy's team members are helpful. They make sure that people have all the information they need so that they can use their medicines safely.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street and the doors were power assisted. There was easy access to the medicines counter. The pharmacy had the facilities to print large print labels and patient information leaflets. The pharmacy had a hearing loop. The store manager was multilingual. And said that she would also call colleagues in other stores to translate or would use online translation services. Most people locally spoke English.

The store manager was new to the store. She said that the new medicines service (NMS) and MUR and services had an impact on people and provided her with a chance to get to know people. She said that with the NMS service, people appreciated having someone check in with them when they started new medicines.

The pharmacy had an established workflow in place. Prescriptions were dispensed by the dispensers and checked by the pharmacists. A large proportion of prescriptions were received electronically including those for controlled drugs. Three main surgeries nearby had stopped accepting requests from pharmacies for repeat prescriptions. People were required to order their prescriptions directly from the surgery. These prescriptions were processed using the Webscript system. Pharmacists very rarely had to self-check and the store manager said that she would take a mental break between dispensing and checking. Pharmacist Information Forms (PIF) forms were used by dispensers to pass on information to the pharmacist including information of any new medicines prescribed or any changes. Or if the prescription had a CD, or if the person was eligible for any services. The dispenser said that she would use these to record any information she wanted to pass onto the RP including any notes from the GP which were flagged on the electronic system.

A quad stamp was used which was initialled by all members of the team to create an audit trail for each stage of the dispensing and supply processes. Dispensed and checked by boxes on labels were also initialled by members of the team. The pharmacy team also used baskets to ensure that people's prescriptions were separated.

When dispensing sodium valproate, a note was made on the PIF with details of the brand the person would usually have. The RP would attach a 'refer to pharmacist' laminate to the assembled prescription to speak to the person when medicines were being handed out. The pharmacist was aware of the change in guidance for dispensing sodium valproate and would check with the person if they were familiar with the guidance. Or see if they wanted to use the consultation room to discuss this. Most people who collected sodium valproate from the pharmacy did not fall within the category.

When dispensing other high-risk medications, the dispenser said that the warning cards were used. And these had prompts on the back relating to the questions that needed to be asked or information that needed to be passed on. INR results were recorded on the patient medication record (PMR) for people

who were regularly taking warfarin.

When medicines which looked alike or sounded alike (LASA) were dispensed, dispensers read the product name aloud when picking stock and marked this on the PIF. The PIF was then ticked when it was dispensed and signed when the RP checked. Head office had identified a list of LASA medicines and lists were stuck on each workstation to prompt the team.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Individual record sheets were in place for each person. Prescriptions were usually ordered a week in advance or for those surgeries which did not accept requests from the pharmacy the technician would either give the surgery or the person a courtesy call to remind them. Prescriptions were checked against the individual record and any missing items or changes were chased up and confirmed with a note made on the individual record. Prescriptions were labelled and stock was collected after which it was clinically checked. Packs were then prepared and sealed after which they were checked by the RP.

Assembled trays observed were labelled with product descriptions, mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly.

Deliveries were carried out by drivers who were based at a hub. People were called prior to arranging delivery. The delivery driver used an electronic device to obtain signatures when medicines were delivered. In the event that the medication could not be delivered it was returned to the pharmacy with a large sticker.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs and those requiring cold storage. Fridge temperatures were monitored and recorded daily, and these were observed to be within range. CDs were kept securely

The pharmacy had been briefed on the Falsified Medicines Directive (FMD) but equipment had not been installed. The store manager was not aware of when this was due to be available to be used in store.

Stock was date checked by the dispensers. Sections were checked on a weekly basis with the whole dispensary completed over 13 weeks. Stock going out of date was highlighted with a short-dated sticker, recorded and removed. There were no date expired medicines found on the shelves sampled. A date checking matrix was in place. Out of date and other waste medicines were segregated and then collected by licensed waste collectors.

Drug recalls were received directly from the MHRA by the store manager and they were also received on Boots Live which the whole team could check. The last actioned alert had been for losartan.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had a range of clean glass crown stamped measures available. Tablet counting trays were available. A separate counter was used for cytotoxic medication to avoid contamination.

Up-to-date reference sources were available including access to the internet.

The pharmacy had a fridge of adequate size.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork/dispensing labels were collected in blue confidential waste bags and then sent to head office for destruction.

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.