

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 Haydock Green, NORTHOLT, Middlesex,
UB5 4AP

Pharmacy reference: 1035053

Type of pharmacy: Community

Date of inspection: 31/07/2019

Pharmacy context

A Boots pharmacy in the centre of a housing development in Northolt. The pharmacy provides essential NHS services. It also provides medicines in multi-compartment compliance aids for 53 people in the community. Additional services include: Medicines Use Reviews (MURs), the New Medicines Service (NMS) and prescription deliveries. Flu vaccinations are provided during the winter flu season.

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 | 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's working practices are safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future. But they are not always thorough enough in the way they capture information and use it to learn and improve.

Inspector's evidence

The pharmacy had procedures for managing risks in the dispensing process. All incidents, including near misses, were recorded at the time and reviewed regularly. Staff said that the pharmacist would discuss ways of preventing a reoccurrence, with the individual involved, as soon as the mistake came to light. 'Look- alike- sound- alike' drugs (LASAs), such as amlodipine and atenolol had warning stickers placed on the shelves in front of them to help prevent a picking error. A list of 12, commonly recognised LASAs, had been placed on the side of computer screens and on the wall in front of the dispensing bench. The list was there to prompt staff to make extra checks when one or more of these drugs was dispensed. The list included amitriptyline, amlodipine, atenolol, allopurinol, prednisolone, propranolol, quetiapine and quinine. When dispensing these drugs, staff were required to write the drug name on a 'pharmacist's information form' (PIF) as a checking prompt. The pharmacist found this useful and felt that it had prevented errors and near misses.

The system for recording near misses had changed two months previously. Records showed that, since the change, staff were required to consider what had contributed to the mistake. Staff had identified that rushing, not reading prescriptions properly or having too much to do had been contributory factors. Several near miss entries referred to prescribing errors rather than considering what the team's responsibilities were when this happened. Near misses and errors were discussed at the time and staff were required to reflect on what had gone wrong and identify what the learning points were. However, this was not captured in the records and therefore may not have been considered in the monthly patient safety review. And, staff had not always reflected on their individual dispensing procedures to help identify any specific steps or checks which could have prevented mistakes. Common near misses in recent months had involved strength and quantity. But there was no reference to how this might be improved upon in the records. However, since the change staff had increased their reporting of near misses and had increased the use of pharmacist information forms (PIFs) to communicate important messages, including the dispensing of LASAs, to the pharmacist.

Sertraline and sildenafil preparations had been separated following an incident. Staff discussed how they also tried to focus on the differences between the two drugs rather than the similarities. It was thought that considering the drugs uses as well as their names may also help prevent a mistake when dispensing. Staff had also had similar discussions about mefenamic acid 500mg tablets and metformin 500mg tablets and other LASAs.

Staff worked under the supervision of the RP whose sign was displayed for the public to see. There was a set of standard operating procedures (SOPs) for staff to follow. Staff had read and signed SOPs relevant to their roles. The pharmacy assistant (PA) had recently completed a dispensing SOP quiz questionnaire to test her understanding of the SOPs.

The pharmacy team had a positive approach to customer feedback. A previous customer survey demonstrated a very high level of customer satisfaction. But, out of stocks were raised as an area for improvement, so staff tried to get out of stock medicines from several different sources, including other local pharmacies with different suppliers. They also used the Alliance direct website which gave an account of the availability of all brands of the drug they were looking for. Staff then shared this information with local GPs to help with what they were prescribing.

The pharmacy had a documented complaints procedure in place. A SOP for the full procedure was available for reference. Customer concerns were generally dealt with at the time by the pharmacist. Information cards were available for customers who wanted to complain to the pharmacy's line manager. Formal complaints would be recorded and referred to the Superintendent. Details of NHS England and local Healthwatch were available on an 'About this pharmacy' leaflet. Staff could also provide a phone number for the Boots customer care service if required. The pharmacy had professional indemnity and public liability arrangements. So, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 31st January 2020 when they would be renewed for the following year.

All the necessary records were kept and were in order, including controlled drug (CD) registers, records for the responsible pharmacist and unlicensed 'Specials'. Records for private prescriptions were also in order. The pharmacy had records for patient returned CDs. Records of returned CDs were kept for audit trail and to account for all the non- stock CDs which RPs had under their control. Records for emergency supplies were generally in order although several entries did not give a clear reason for supply.

Staff had undergone Information governance training and had completed the Boots online 'e-learning' module.

Discarded labels and tokens were put into a separate blue confidential waste bag in a confidential waste bin and collected for safe disposal by a licensed waste contractor. Completed prescriptions awaiting collection were stored in deep plastic storage tubs in the dispensary where details could not be viewed from customer areas.

The regular pharmacist had completed CPPE level 2 training. All staff had been briefed on the principles of safeguarding. They had completed the Boots online 'e-learning' module and dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report at this store. Contact details for the relevant safeguarding authorities were available online.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services

Inspector's evidence

In general, pharmacy services were managed by the regular RP, a full- time pharmacy adviser (PA) two part- time PAs and a part- time trainee PA. At the time of the inspection, which was during the school summer holiday period, the pharmacy was quiet, and the team consisted of the RP and a part- time PA. The position of a PA combines the training of a medicines counter assistant (MCA) and a dispenser. The team were up to date with their workload.

Staff and pharmacists had regular performance reviews. The PA said she could raise issues with the regular pharmacist if she needed to. She could also raise issues with other line managers. She described requesting a second computer in the dispensary to help manage the workflow and her request was accepted. She also described how, as patient safety champion, she had taken hints from other stores on how to improve safety. As a result, staff had been retrained on the calculation of paediatric doses using the training and information card produced by the superintendent's office. Their general awareness of paediatric medicines had also been enhanced.

The pharmacy's team members undertook regular training through the Boots online training programme. They were observed to work well together and it was clear that each member of staff knew what they had to do and when. They were observed discussing issues and helping each other out when required. Although there were targets in place, the pharmacist reported that these did compromise patient care. She described how she would prioritise the prescription service over advanced services when the workload was high.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services. Staff made efficient use of the limited space available to them.

Inspector's evidence

The pharmacy's premises were on a small parade of shops in the centre of a built-up housing development. They consisted of a small shop floor area and compact dispensary. Although small, the pharmacy was bright and clean. It had clean work surfaces, sinks, and shelves and had a professional appearance. The pharmacy had a consultation room for private consultations and a small chemist counter. Pharmacy medicines ('P' medicines) were stored in cabinets with glass doors behind the counter. This was to manage customer access to medicines requiring greater pharmacy control. The pharmacy was bright and well ventilated with temperature controls in place. It had a professional appearance and stocked items related to healthcare.

The dispensary had a clear work flow. It had a combination of pull out drawers and open shelving for storing stock, files and folders. It had a U-shaped run of dispensing bench to three sides of the dispensary with a full height shelving unit in the centre, for storing stock. Waiting prescriptions were dispensed on a specific area of work surface. Accuracy checking took place on bench space which overlooked the medicines counter. Non-urgent dispensing activity was managed in accordance with available work space. Multi-compartment compliance aids were dispensed and checked on a side area of work surface. They were dispensed and checked in batches before being cleared away ready for delivery or collection, leaving the work space free for other activity. Deliveries of dispensary stock were checked off and put away in the afternoon when there was more free space available.

Work surfaces were free of unnecessary clutter. Staff were seen to clear surfaces as they worked. Prescriptions were bagged and stored promptly after checking. The pharmacy had no stock room or dedicated staff area but had toilet and hand washing facilities. Staff used a small area of bench at the rear of the dispensary for making hot drinks and heating food. Staff had requested stools to provide some rest and comfort during day when having their lunch breaks. This area was not used for dispensing.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. Team members are good at giving people the advice and support they need to help them use their medicines safely and properly. In general, the pharmacy manages its medicines safely and effectively. It carries out most of the checks that help make sure that its medicines are fit for people to take.

Inspector's evidence

Opening hours were clearly displayed on the door and services were promoted at the pharmacy window and on the company website. A range of information leaflets were displayed in a rack at the front door and in the consultation room. The pharmacy had a wide automatic door and step-free access, suitable for wheelchair users. Once inside there was sufficient space for wheelchair users to move around. Wheelchair users would also be able to access the consultation room. There was a prescription delivery service for those unable to collect their own medication. The pharmacist was overheard offering the service to an elderly customer.

SOPs had been signed as read and understood by staff. A sample of SOPs was checked regarding the management of CDs and the assembly labelling and accuracy checking process. Observation of staff performing these activities indicated that procedures were being followed. For example, there was a clear audit trail of the dispensing process and CD records were maintained with weekly stock counts. A random check of CD stock (Oxycontin 20mg capsules) indicated that the running balance quantity was correct. Team members attached notes and PIFs to prescriptions to alert the pharmacist to any medication changes or any matters requiring her intervention. Laminated cards were attached to prescriptions for high-risk medication such as methotrexate or lithium to prompt the pharmacist to provide additional counselling.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group, taking sodium valproate. The pharmacist described supplying valproate warning cards and booklets with relevant prescriptions and referred to the MHRA guidance sheet. In conjunction with the local GP practice, all patients in the at-risk group had been identified and counselled. Packs of sodium valproate in stock bore the updated warning label and additional warning stickers were available for split packs. Staff also described giving similar counselling to patients on isotretinoin preparations. A laminated guidance sheet for isotretinoin preparations was available for staff to refer to.

Multi-compartment compliance aids were provided for patients who needed them. Medicines summary sheets were created for each person and checked against prescriptions each time. Staff would pursue discharge letters after being informed that people had been in hospital. Patient information leaflets (PILs) were offered with new medicines and on a regular basis thereafter. PILs were supplied to everyone except those who didn't want them. Compliance packs also contained a description of the medication, including colour and shape, to help people to identify them and gave the required BNF advisory information to help people take their medicines properly. The pharmacy also had a system for tracking the ordering and receipt of each prescription and the dispensing and supply of medicines for each compliance pack patient. Staff managed the workload by requesting the prescriptions, on people's behalf a week in advance. To give enough time to receive the prescription, manage queries, order stock, dispense, check and get them ready for delivery on time. Dispensing of compliance packs took place in accordance with a 4-week rota.

Medicines and Medical equipment were obtained from established wholesalers, with the appropriate licences; Alliance Healthcare, Phoenix and AAH. Unlicensed 'specials' were obtained from BCM specials. The pharmacist described how she helped minimise the impact medicines shortages had on patients, by liaising with the surgery and other pharmacies. Stock was tidy and organised, and date checked regularly. Items with a short shelf life remaining were highlighted. No out-of-date products were found on dispensary shelves. Items requiring refrigeration were stored in a medical grade fridge for which temperatures were recorded and monitored. CDs requiring safe custody conditions were stored in the appropriate cabinets. Staff were aware of the European Falsified Medicines Directive (FMD). The pharmacy had the hardware for FMD scanning and were aware of FMD requirements. They had not yet had any training on FMD requirements and were awaiting the software along with a new computer system.

Waste medicines were disposed of in the appropriate containers. But, there was no list of Hazardous items requiring separate disposal available for staff to refer to. The list would help ensure that all waste medicines were disposed of appropriately. Drug recalls and safety alerts were responded to promptly and records were kept. A recall for aripiprazole, received that day, had been acted upon with none of the affected stock found. Records were filed electronically so that locums could find them more easily if they needed to.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had the equipment and facilities it needed. Equipment was in good working order, clean and appropriately maintained. Tablet and capsule counting trays and measuring equipment were generally clean although one triangle contained a dusty tablet residue. Measures were BS standard and clean although one was slightly lime-scaled. There was a separate counting triangle for cytotoxic tablets to prevent cross contamination with other tablets although this was not currently being used. Dispensing bottles were capped to prevent contamination with dust and debris.

The pharmacist used medicines complete as one of her reference sources along with several other on-line resources. There were also hard copies of the most recent BNF and BNF for children and the drug tariff. The pharmacist also used other information sites such EMC. There were two computers for staff to use. One in the main dispensary, and one in the consultation room. This appeared to be sufficient for the workload. All computers were password protected and were out of view of patients and the public. Patient sensitive documentation was stored out of public view in the pharmacy and confidential waste was collected regularly for confidential disposal. Staff were observed using their own smart cards when accessing patient records.

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. |