General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 716 Field End Road, RUISLIP, Middlesex, HA4 0QP

Pharmacy reference: 1035088

Type of pharmacy: Community

Date of inspection: 17/05/2019

Pharmacy context

A Boots pharmacy on a busy main road running through Ruislip. The pharmacy provides essential NHS services. It also provides medicines in multicompartment compliance aids (MDS trays) for 42 patients in the community. Additional services include; Medicines Use Reviews (MURs) and the New Medicines Service (NMS).

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 and keep people's information safe. The team identifies and manages risks well. It logs any mistakes it makes during the dispensing process. It learns from these and takes action to avoid problems being repeated. The pharmacy responds well to people's feedback by making changes to improve the quality of its services.

Inspector's evidence

The pharmacy was run by a regular responsible pharmacist (RP). Her days off were covered by regular boots relief pharmacists. The rest of the team consisted of two trainee pharmacy advisers and two trainee technicians.

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. The team showed how 'look- alike- sound- alike' drugs (LASAs), such as Amlodipine and Atenolol had warning stickers placed on white cartons 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 recently changed. Records showed that staff were also required to consider what had contributed to the mistake. Near misses and errors were discussed at the time and staff were required to reflect on what had gone wrong and what the learning points were. Staff were required to reflect on their individual dispensing process to help identify any specific steps or checks which could have prevented the mistake. Common near misses in recent months had involved strength and quantity. Consequently, the individuals concerned were required to make a conscious effort to check quantity and strength each time. They did so by placing a circle around the quantity figure or the strength figure on medication packs as they were dispensing.

Sodium Valproate, and Sodium Valproate controlled release preparations, had been separated following an incident, to help prevent a reoccurrence.

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 team had a positive approach to customer feedback. A previous customer survey demonstrated a very high level of customer satisfaction. But, people had also fed back that they felt the pharmacy was not as clean as it could be. Out of stocks were also raised as a concern. Since then, a

cleaning rota was in place and staff tried to get out of stock medicines from several different sources, including other local pharmacies, which may have different suppliers.

The team described how they ordered the same brands of medicines for certain people to help with compliance. Customer preferences included the Almus brand of Warfarin. The team had added notes to the patient medication record (PMR) as a reminder for staff dispensing and checking them. A reminder was also printed on the labels.

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. 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 and emergency supplies 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.

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 were stored in deep drawers in the dispensary where details could not be viewed from customer areas.

The regular pharmacist and one of the trainee technicians had completed CPPE level 2 training. The other trainee technician had achieved level 1. 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 well and team members use their professional judgement to make decisions in the best interests of people. Pharmacy team members work well together. They are comfortable about providing feedback to each other and are involved in improving the pharmacy's services.

Inspector's evidence

The pharmacy was manned by the regular Responsible Pharmacist, two trainee Technicians and a trainee pharmacy adviser (medicines counter assistants/dispensing assistants). The team were up to date with their workload.

Staff and pharmacists had regular performance reviews. A trainee technician said she could raise issues with the regular pharmacist if she needed to. She could also raise issues with other line managers. The second trainee described how she helped to supervise new staff on the counter so that they made the correct checks when handing out patient medication. She also helped staff to put stock away tidily and in an organised fashion. She had suggested reorganising the system for repeat batch prescriptions so that the next prescription in the batch could be retrieved more easily and dispensed in time for its due date. Her suggestion had been implemented and appeared to be working.

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 she would not allow these to 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 premises are clean, secure and suitable for the services it provides.

Inspector's evidence

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 glass doored cabinets behind the counter. This was to manage customer access to medicines which require greater pharmacy control.

The dispensary was laid out with several work stations and had a clear work flow. It had a combination of pull out drawers and open shelving for storing stock, files and folders. It had an L-shaped run of dispensing bench. Waiting prescriptions were dispensed on a specific area of bench. Accuracy checking took place on bench space which overlooked the medicines counter. Multicompartment compliance aids (MDS trays) were dispensed in a small galley area behind the dispensary. They were then placed on shelves in the dispensary for checking.

Work surfaces were free of unnecessary clutter. Staff were seen to clear surfaces as they worked. Prescriptions were bagged and stored promptly after checking. MDS trays were prepared and stored on shelves in the back area of the dispensary.

The pharmacy had a stock room, staff facilities and a fire door to the rear.The pharmacy was secured by a shutter, an alarm system and CCTV. The consultation room was kept locked when not in use to prevent unauthorised access.

The pharmacy was bright and well ventilated with temperature controls in place. It had a professional appearance and only healthcare related items were stocked in its vicinity.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. Members of the pharmacy team give people the advice and support they need to help them use their medicines safely and properly. The pharmacy team checks stocks of medicines regularly to make sure they are in-date and fit for purpose. The pharmacy gets its medicines from reputable sources and stores them appropriately. And it also disposes of people's waste medicines safely. In general, the pharmacy manages its medicines safely and effectively. But, it is not yet scanning products with a unique barcode, as required in law.

Inspector's evidence

Opening hours were clearly displayed on the door. Services were promoted at the pharmacy window and on the company website. A range of information leaflets were displayed in the waiting area.

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.

Stickers and notes were used 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. PIFs were also used.

Procedures were in place to ensure that female patients in the at-risk group were adequately counselled when receiving Sodium Valproate medication. The pharmacist said that counselling was offered to all women regardless of age. Packs of Sodium Valproate contained the appropriate warnings. Cards and leaflets were available for supply although the cards had not yet been issued.

Monitored Dosage System (MDS) trays were provided for patients who needed them. Product Information Leaflets (PILs) were supplied regularly. The medication in MDS trays was described on the medication sheet to help patients and carers identify the medicines.

Each MDS patient had their medicines listed on a summary sheet. The pharmacy also had a system for tracking the ordering and receipt of each prescription and the dispensing and supply of medicines for each MDS patient. Staff managed the MDS workload by requesting the prescriptions, on people's behalf up to two weeks 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 MDS trays 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.

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. Fridge temperatures were recorded and monitored.

The pharmacist described how she helped minimise the impact medicines shortages had on patients, by liaising with the surgery and other pharmacies.

Staff were aware of the European Falsified Medicines Directive (FMD). The pharmacy did not have the hardware for FMD scanning and were unaware of FMD requirements. They had not yet had any training on FMD requirements.CDs requiring safe custody conditions were stored in the appropriate cabinets.

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.

Drug recalls were recorded and filed for future reference. Records were signed and dated to show that checks had been made for the items concerned. A recent recall for Pfizer Ativan 4mg/ml solution for injection had been acted upon with none of the affected stock found.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, the pharmacy uses its facilities and equipment to keep people's information safe. But, could do more to ensure that staff have the appropriate level of access to patient records.

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 clean. Measures were BS standard and clean. There was a separate counting triangle for cytotoxic tablets to prevent cross contamination with other tablets. Dispensing bottles were capped when in storage 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 three computers for staff to use. Two 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. But staff were observed using the pharmacist's smart card rather than their own.

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.