General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 380 Long Lane, Hillingdon, UXBRIDGE, Middlesex, UB10 9PG

Pharmacy reference: 1035176

Type of pharmacy: Community

Date of inspection: 20/01/2020

Pharmacy context

A Boots pharmacy on a busy main road running through a residential area of Hillingdon. As well as the NHS Essential Services, the pharmacy provides medicines in multi-compartment compliance packs for local people. It also It also provides substance misuse support services including supervised consumption and a seasonal flu vaccination service. Other services include; Medicines Use Reviews (MURs), a New Medicines Service (NMS) and a smoking cessation service.

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	1.1	Good practice	Team members discuss any mistakes they make. They are good at minimising the chance of mistakes happening. And they are good at recognising what could go wrong to help reduce the chance of making mistakes in future.
		1.2	Good practice	The pharmacy team is good at reviewing its processes. And it is good at recognising what could go wrong to help reduce the chance of making mistakes in future. This means that services can continue to be delivered safely and effectively.
		1.3	Good practice	The pharmacy is good at making sure its team members understand their responsibilities and follow its procedures. This means that services can continue to be delivered safely and effectively.
2. Staff	Standards met	2.5	Good practice	Team members work well together. They can make suggestions about how to improve the pharmacy's services. This means that they are able to support one another to deliver services well.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy is good at managing its services. This means that it can provide its services safely, effectively and efficiently.
		4.3	Good practice	The pharmacy is good at giving people the advice they need to help them take their medicines properly. This means that people canmore fully benefit from them.
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 they are good at making sure their procedures are followed. They listen to people's concerns and keep people's information safe. Team members discuss any mistakes they make. They are good at minimising the chance of mistakes happening. And they are good at recognising what could go wrong to help reduce the chance of making mistakes in future.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP) whose sign was displayed for the public to see. There was a set of up-to-date standard operating procedures (SOPs) in place. Staff had read and signed the SOPs relevant to their roles. The pharmacy had procedures for managing risks in the dispensing process. All incidents, including near misses, were discussed at the time and recorded as soon as possible afterwards. The RP said that she discussed all near misses with the individual involved, as soon as they came to light. The team also had regular meetings for reviewing and discussing any mistakes and ways of preventing a reoccurrence. Records described how the RP had monitored staff compliance with the prescription hand-out procedure for substance misuse clients, following guidance issued by the superintendent's office. Monitoring would continue until all staff were seen to comply with procedure every time they handed out a substance misuse prescription. Staff were required to take extra care when selecting 'look alike sound alike' drugs (LASAs) such as amitriptyline and atenolol, prednisolone and propranolol. The pharmacist had placed a list of LASAs on computer monitors and in dispensing areas as a reminder. When they received a prescription for a LASA, team members added a note to the pharmacist's information form (PIF), to alert the person dispensing and checking.

The pharmacy used the Columbus electronic scanning system, where items selected were scanned for accuracy. The two most common types of near miss, not picked up by the scanning process, were due to staff selecting the wrong form of drug or printing out incorrect dosage directions on the label. The monthly patient safety report referred to a number of risk areas around dosage directions, LASAs, prescription hand-out procedures and product recalls, but didn't make reference to mistakes made with drug form. But the RP described how pharmacists would get a second check of item against prescription and label at the accuracy checking stage as an additional check.

The system for recording near misses showed who was involved, possible causes and any learning points. Mistakes appeared to be relatively rare. The RP had reminded staff that picking errors, detected by the scanning system, should still be recorded much as they would if it had been detected by a member of the team. Staff were required to reflect on their own dispensing procedures to help identify any specific steps or checks which could have prevented the mistake. The company's accuracy checking tool was depicted on a laminated card on display in dispensing areas, for staff to refer to. The pharmacist described how she had coached staff to use the checking tool to ensure they had made all the necessary checks when dispensing. And she tried to encourage them to use the tool in a way which worked for them.

The pharmacy team had a positive approach to customer feedback. A few customers were concerned by the availability of some medicines. The electronic system provided staff with the means of checking the availability of medicines from suppliers. It also informed them when a medicine was likely to

become available again. The RP said that she tried to establish in advance, when someone would run out to give her time to request an alternative prescription for them.

The pharmacy had a documented complaints procedure. Where possible, customer concerns were dealt with at the time by the regular RP. Formal complaints and dispensing incidents would be recorded and referred to the superintendent. But she said complaints were rare. Details of the procedure were available in the SOP and details of the local NHS advocacy service and PALs could be provided on request. Details of NHS England and local Healthwatch were available on an 'about this pharmacy' leaflet which was on display for selection. The leaflet also contained, a number for the Boots customer care service, at head office. 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 private prescriptions, emergency supplies, the responsible pharmacist (RP) and unlicensed 'specials' were also in order. The pharmacy had records for CDs returned by people. 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 on confidentiality. Discarded labels and tokens were discarded into a separate, blue confidential waste bag in a confidential waste bin. And collected for safe disposal by a licensed waste contractor. Prescription forms were filed in lockable drawers in the dispensary. Completed prescriptions for collection were stored in drawers near the counter. The drawers were deep enough to keep prescription details out of view. The regular pharmacists had completed CPPE level 2 training on safeguarding. And the dispenser had completed CPPE level 1. All staff had been briefed on the principles of safeguarding and completed the Boots online 'e-learning' module and dementia friends training. The pharmacy team had not had any specific safeguarding concerns to report. 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 and are good at supporting one another. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services.

Inspector's evidence

The pharmacy had two regular responsible pharmacists (RPs). One of the pharmacists was also the manager and worked full-time. The other pharmacist worked to cover days off and holidays. The rest of the team consisted of two full-time dispensers and two part-time staff who doubled up as dispensers and medicines counter assistants (MCA)s. The dispenser MCAs were also trained to carry out basic dispensing activities and were known in Boots as pharmacy advisors (PAs). On the day of the inspection the RP was supported by a dispenser PA and a trainee pharmacy advisor working as a MCA. She had been brought in from another store to assist with staff shortages. The trainee pharmacy advisor was undergoing training on the Columbus system.

Team members were observed to work effectively together. They were seen assisting each other when required. The daily workload of prescriptions was up to date and customers were attended to promptly. Staff described being able to raise concerns. The dispenser said he could discuss any issues with pharmacists and the rest of the team. The pharmacy had a small, close-knit team and staff felt able to raise concerns with the regular pharmacists if they needed to. The dispenser on duty had taken the lead with organising and managing the multi-compartment compliance pack service. And his colleague had introduced the idea that the team should check all its electronic systems each morning, to ensure that they were up to date with SONAR, NHS emails and patient referrals as well as Boots' internal communications. The RP was able to make her own professional decisions in the interest of patients and felt able to manage targets as part of the daily workload. She said she would offer an MUR to patients who needed them. She prioritised MURs for patients on high risk medicines such as anti-coagulants, anti-platelets, NSAIDs and diuretics and hospital discharge patients.

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.

Inspector's evidence

The pharmacy was in the centre of the local residential community, in a commuter belt of north west London. In general, it had a bright, modern appearance. It had a double front with full height windows, and a glass door to provide natural light. The pharmacy had a traditional layout with customer areas and the pharmacy counter to the front and the dispensary behind. Aisles were kept clear of obstructions and were wide enough for wheelchair users. There was a small seating area for waiting customers. The pharmacy had a consultation room to the side of the counter, which the pharmacist used for private consultations and services such as flu vaccinations. The door into the consultation room was locked when not in use. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The dispensary was spacious. It had a five to six metre run of work bench to one side and a run of shelving and drawer units, for storing medicines, on the other. The area of dispensing bench nearest the counter was where most of the dispensing and checking took place. Multi-compartment compliance pack dispensing took place on the area of bench space furthest away from the counter where it was slightly quieter. Work surfaces were clean, tidy and organised and there was a clear work flow. Completed prescriptions were stored in drawers in the dispensary where they could not be viewed by the public. Access to the dispensary was authorised by the pharmacist. The consultation room could be accessed by the public via a door from the shop floor. The rear area of the pharmacy had a small staff area and staff facilities. The pharmacy was tidy and organised and had a professional appearance. Shelves, work surfaces, floors and sinks were all clean.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at providing its services safely and effectively. And it makes them available to everyone. It manages its medicines safely and effectively and gives people the advice they need to help them take their medicines properly. The pharmacy is good at helping people to benefit from their medicines. The pharmacy's team members check stocks of medicines regularly to make sure they are in date and fit for purpose.

Inspector's evidence

A selection of services were advertised on the pharmacy window. But some of the pharmacy's services were not promoted, including the pneumonia vaccination service. There was a range of information leaflets available for customer selection in the consultation room and on the healthy living display near the waiting area. The pharmacy had step-free access from outside and an automatic door. Aisles were wide and kept clear of obstructions. They were wide enough for wheelchair users to move around. The consultation room was of a size suitable for wheelchair access. The pharmacy offered a prescription collection service and a prescription ordering service for those who needed help to manage their prescriptions.

There was a set of SOPs in place, several of which had been reviewed and updated recently. Staff appeared to be following the SOPs. A CD stock balance was carried out every week in accordance with the SOP. And the quantity of stock checked (Oxynorm 20mg capsules) matched the running balance total in the CD register. Multi-compartment compliance packs were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with each supply. The medication in compliance packs was given a description, including colour and shape, to help people to identify their medicines. This also helped people to identify and remove tablets such as soluble aspirin which needed to be dissolved in water before taking. The labelling directions on compliance packs gave the required BNF advisory information to help people take their medicines properly.

Pharmacists were aware of the need to counsel patients, in the at-risk group, taking sodium valproate. Team members had warning cards and information booklets to help them provide the appropriate information if needed. Packs of sodium valproate in stock bore the updated warning label. Newer packs had the removable warning cards attached to packs. And a sticker had been added to the shelf edge in front of products to act as a reminder for staff. The pharmacy also had additional warning labels if needed. The pharmacy had one patient in the at-risk group taking the medication. The RP had provided counselling by phone as the patient's partner usually collected her medication. The RP had also placed a warning card and a booklet in with her prescription.

The pneumonia vaccination service was delivered in accordance with an up-to-date PGD and SOP. Patients were required to complete a questionnaire and asked to sign a consent form. The pharmacy kept records of all consultations and details of the product administered. The pharmacy had procedures for dealing with cases of anaphylaxis. Following vaccination, patients were given a slip to take to their GP and a form containing follow up information and details of the pharmacy's complaints procedure. The pharmacy was a healthy living pharmacy. It had a healthy living display, promoting 'dry January' giving information on alcohol awareness.

Medicines and Medical equipment were obtained from established wholesalers; NWOS, Alliance Healthcare, Phoenix and AAH. Unlicensed 'specials' were obtained from BCM specials. All suppliers held the appropriate licences. Stock was generally stored in a tidy, organised fashion. A CD cabinet and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read and recorded daily. Stock was regularly date checked and records kept. But the team were not yet scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD) requirements.

Waste medicines were disposed of in the appropriate containers and collected by a licensed waste contractor. Staff had placed a list of hazardous waste on the wall for easy reference. The list was available to help ensure that all medicines were disposed of appropriately. The pharmacy had a separate container and separate disposal arrangements for cytotoxic medicines. Drug recalls and safety alerts were acted upon promptly. Records were kept for recalls of items which the pharmacy stocked. One split box of ranitidine 300mg tablets had been removed from stock following one of the December recalls for ranitidine 150mg tablets and 300mg tablets. The split box of tablets had been returned to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, it uses its facilities and equipment to keep people's information safe.

Inspector's evidence

The pharmacy had a CD cabinet for the safe storage of CDs. The cabinet was secured with smaller bolts than expected. The RP would check to ensure that fixings complied with regulatory requirements. The pharmacy had the measures, tablet and capsule counting equipment it needed. Measures and tablet triangles were of the appropriate BS standard and clean. Precautions were taken to help prevent cross contamination by using cytotoxic tablets in foil strips. And amber dispensing bottles were stored with their caps on to prevent contamination with dust and debris. CD denaturing kits were used for the safe disposal of CDs. The pharmacy team had access to a range of up-to-date information sources such as hard copies of the BNF, the BNF for children and the drug tariff. They also used 'medicines complete' an on line app which provided access to Stockley for drug interactions, the BNF and BNF for children and Martindale. The pharmacist also accessed EMC and NICE online.

The pharmacy had three computer terminals available for use. One in the dispensary, one on the counter and one in the consultation room. All computers had a PMR facility, 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 for safe disposal. Staff generally used their own smart cards when working on PMRs. Staff generally used their own smart cards to maintain an accurate audit trail and to ensure that access to patient records was appropriate and secure.

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.