General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 122 Holborn, LONDON, EC1N 2TD

Pharmacy reference: 1040246

Type of pharmacy: Community

Date of inspection: 14/01/2020

Pharmacy context

The pharmacy is located on the high street in a busy mixed residential and commercial area with people working locally in central London. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include supply of a range of travel medicines and vaccinations, substance misuse and mole screening. The pharmacy has healthy living status.

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	The pharmacy team identifies and manages the risks associated with providing pharmacy services by a variety of mechanisms including up to date written procedures underpinning all services which they understand and follow.
		1.2	Good practice	The pharmacy team records and reviews its mistakes and can give examples of action taken to stop the same sort of mistakes happening again.
2. Staff	Standards met	2.2	Good practice	The pharmacy's team members are supported in keeping their skills and knowledge up to date through regular ongoing training.
		2.5	Good practice	Staff are encouraged to provide feedback to the pharmacists and are involved in improving the pharmacy's services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy provides a range of services and it makes it easy for people to use them. For example by opening early and providing hearing loops and large print information.
		4.2	Good practice	The pharmacy team manages and delivers services safely and effectively. It takes extra care with high risk medicines including valproate, warfarin and methotrexate and makes sure people take their medicines safely.
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. The pharmacy manages risk well and it has written procedures which tell staff how to complete tasks effectively. It keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed but the pharmacist said the number of near misses had decreased since the introduction of the new Columbus computer system. The prescription was scanned to generate labels and prescription image. If the incorrect item was picked and scanned, a warning message appeared on the screen. Stock was ordered automatically by Columbus during the dispensing process.

'Lookalike, soundalike' (LASA) medicines laminates and 'select and speak it' alert labels were displayed to reduce picking errors. Information was collated by staff in the patient safety review (PSR) and a trend in quantity errors during the dispensing process was highlighted and there were no LASA errors. The PSR included information on current recalls and alerts and there was an action point to re-read the relevant procedure following an incident reported on the incident reporting system. A further action point had identified reducing multi-tasking when dispensing to reduce distraction and possible errors. The latest Professional Standard (December issue) had been read and signed by staff and included information on the NHS Community Pharmacist Consultation Service (CPCS) and a case study.

Workflow: tubs were in use to separate prescriptions and medicines during the dispensing process. The pharmacist performed the clinical and final check of prescriptions and completed the dispensing label audit trail. The four-way stamp was initialled to identify staff involved in dispensing, checking and handing out of medication. Special messages were recorded on the pharmacist information form (PIF) including high-risk and LASA medicines, controlled drugs (CDs), owing medicines and interactions. Interactions between medicines for the same patient were checked by the pharmacist during the clinical check. The expiry date of validity of controlled drug (CD) prescriptions was recorded. A PIF was seen to be added to each prescription at the time of the visit and coloured, laminated cards were added to highlight prescriptions for high-risk medicines. There were designated dispensing and checking areas in the dispensary. A visual aid for the three-way check of prescriptions was displayed. There was a procedure for dealing with outstanding medication. The original prescription was retained, the PIF endorsed and an owing slip was issued to the patient. Owings were tracked on an owing information screen on the computer. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients on a rolling basis to manage workload and available work space. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. A risk assessment for suitability of the service for a patient was completed.

folder retained information regarding compliance aids and each patient had their own polythene

sleeve containing their discharge summaries and Medisure patient record which was re-printed each time there was a change in medication. A record of communication regarding the patient and the compliance aid was retained.

Labelling included a description to identify individual medicines and patient information leaflets (PILs) were supplied with each set of compliance aids. High-risk medicines such as alendronate were generally supplied separately to the compliance aid but alendronate could be positioned separately in the compliance aid if necessary. The dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in compartments positioned to ensure it was taken before other medication or food. Special instructions were highlighted on the backing sheet.

The annual patient questionnaires had been submitted but the results were not known yet at the time of the visit. Members of the pharmacy team were up-to-date with training in standard operating procedures (SOPs) at the time of the visit. The pharmacy advisor who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. The pharmacy advisor said she would not sell Nurofen Plus and Solpadeine Max to the same patient because they both contained codeine. The pharmacy advisor explained why three packs of Sudafed would not be sold to the same member of the public.

To protect patients receiving services, there was valid professional indemnity insurance in place. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions and 'specials' supplies were mostly complete. Patient group directions (PGDs) and SOPs to administer a range of medicines and vaccinations were retained in a folder. The SOP for mole screening was updated every two years. Travel vaccination PGDs and Sops were due to be updated. The test and treat cystitis PGD was valid. Malaria prophylaxis was available via Boots online service. Both pharmacists were trained to deliver services.

The CD and methadone registers were generally complete, and the balance of CDs was audited weekly in line with the SOP. A random check of the actual stock of Morphogesic 30mg tablets reconciled with the recorded balance in the CD registers. Footnotes correcting entries were mostly signed and dated. There were loose pages in the methadone register which may be at risk of becoming detached and lost. FP10MDA prescriptions were endorsed at the time of supply of medication. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). A privacy notice was displayed. Confidential waste paper was collected for safe disposal and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training. The pharmacists had undertaken level 2 safeguarding via Centre for Pharmacy Postgraduate Education (CPPE). A list of contact details to report safeguarding concerns was displayed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team works well together and manages the workload within the pharmacy. Pharmacy staff are actively encouraged to complete ongoing training. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: two full-time pharmacists, one full-time pre-registration pharmacist, one full-time dispenser and one full-time medicines counter assistant and one trainee medicines counter assistant. Staff were allocated protected learning time to complete training.

One pharmacist was the pre-registration tutor. The pre-registration pharmacist was enrolled on the Boots pre-registration training course and attended regular training days. There was allocated learning time and study topics included first aid, calculation tests and first aid. The pre-registration pharmacist was expected to complete a project on community pharmacy. There was an appraisal every 13 weeks to monitor progress in training and identify where support could be provided.

Staff had their own online training profile and were provided with ongoing training appropriate to their role via eLearning and tutor packs. There was protected learning time to complete training. On completion of a study topic there was a knowledge test. Staff were required to read the PS, SOPs such as the CD SOP and Serious Shortage Protocols. ELearning topics included Health and Safety (stairs, manual handling) and information governance. Pharmacy Quality Scheme (PQS) training included CPCS, safeguarding, sepsis, reducing LASA errors and risk management. An incident regarding supply of the incorrect quantity of medication had been risk assessed to prevent a future repeat incident.

Staff performance was monitored via annual appraisal and regular reviews. Pharmacists attended 'Let's Connect' events annually to meet with peers, be updated on company news and complete some continuing professional development. Staff felt able to provide feedback. They had discussed how to speak to patients and encourage them to have a flu vaccination. A laminated 'flu PIF' was devised and added to prescriptions of at-risk patients who would benefit from the flu vaccination. The flu PIF prompted staff to signpost the patient to the flu vaccination service. There was a whistleblowing policy. Staff said targets and incentives were not set in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

Inspector's evidence

The pharmacy premises were clean, tidy and presented a professional image. There was a Boots optician store located beyond the pharmacy and dispensary. The lavatory facilities were hygienic and handwashing equipment was provided. The consultation room was locked when not in use and protected patient privacy. Staff commented that the consultation room had limited space to accommodate wheelchair users or if a chaperone was present with the person and the pharmacist during a consultation. Posters were displayed relating to safe sharps disposal, dealing with needlestick injury and anaphylaxis. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. They know what to do if any medicines or devices need to be returned to the suppliers. They make sure that people have all the information they need so that they can use their medicines in the right way. The pharmacy team members give advice to people about where they can get other support.

Inspector's evidence

There was wheelchair access and a hearing loop to assist hearing impaired people. Large font PILs could be printed to assist visually impaired patients. Staff could converse in Portuguese, Chinese, Somali and Hindi to assist patients whose first language was not English. Patients were signposted to other local services including walk-in clinic, genito-urinary medicine (GUM) clinic for sexual health screening, the optician and Moorfield's eye hospital and private doctors nearby. Members of the public could obtain a prescription for malaria prophylaxis via Boots online prescribing service.

The pharmacist described the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) to be explained. The intervention was recorded on the patient medication record (PMR). The pharmacist was aware of the procedure to supply isotretinoin to people in the at-risk group. The treatment had to be initiated by a consultant and would be supplied following a negative pregnancy test result. The patient would be counselled on PPP and the intervention recorded on the PMR. The prescriber was contacted regarding intervention for prescriptions for more than 30 days' supply of a CD. Interventions were recorded on the PMR showing checks that medicines were safe for people to take and appropriate counselling was provided to protect patient safety.

High-risk medicines requiring counselling were highlighted on the PIFs and a laminated card was included with the prescription. CD prescriptions were highlighted with the 28-day expiry date recorded on the PIF and a coloured laminated card. The pharmacist said that when supplying warfarin and in line with the questions on the reverse of the warfarin laminated card, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding including internal bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. Evidence of INR was required for the pharmacy to request repeat prescriptions. People taking methotrexate were reminded about the weekly dose and when to take folic acid. EPS prescriptions included a message when blood tests were due. People were advised to seek medical advice if they developed an unexplained fever.

An audit had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drug (NSAID). Other audits included: use of inhalers in asthma treatment in children and adults, identifying people in the at-risk group taking sodium valproate, monitoring patients taking lithium and diabetic patients regarding foot checks and retinopathy screening. In the health zone there was information relating to 'blood in pee', NHS 111, seeking medical advice for coughs after three weeks and claiming free prescriptions in error. There was

information to increase public awareness of flu vaccination, urinary retention, ‘Come and See Us’ pharmacy advice campaign, dry January and Stoptober.

Medicines and medical devices were obtained from Alliance, AAH and Phoenix. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded on an ongoing basis. One section of the dispensary was checked per week and short-dated stock was marked with a sticker. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer’s packaging. Cold chain items were stored in two medical fridges. One fridge was used for stock and one for vaccines. Uncollected prescriptions were cleared from retrieval every four weeks after the patient had been contacted. CD prescriptions were highlighted with stickers and on a PIF to ensure they were not given out after the 28-day validity period. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was integral to the Columbus computer system and was operational at the time of the visit. Drug alerts and recalls were printed, actioned, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people’s private information safe.

Inspector's evidence

Current reference sources included eBNF. The dispensary sink required treatment to remove some limescale. There were stamped glass measures to measure liquids including separate marked measures for methadone. The medical fridges were in good working order. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts. In the consultation room, there were two sharps disposal bins for vaccination sharps. The resuscitation kit included in-date Emerade and Jext devices for use in the event of anaphylaxis. There were syringes, needles and adrenalin ampoules available as a back-up. Flu vaccine PILs were kept in the consultation room for supply with the vaccination. The mole scanner was tested and calibrated annually. The pharmacy computer was password protected and backed up regularly. There was a cordless phone to enable a private conversation. Staff used their own NHS cards.

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.