General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 410 Holloway Road, LONDON, N7 6QA

Pharmacy reference: 1040354

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

This is a pharmacy located in a parade of shops on a busy high street. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also provides flu vaccinations and a hair retention programme.

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors it. This helps team members keep their knowledge and skills up to date.
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

Overall, the pharmacy identifies and manages the risks associated with its services to help provide them safely. Team members are good at recording and regularly reviewing any mistakes that happen during the dispensing process. This helps them make the pharmacy's services safer. The pharmacy protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It mostly keeps its records up to date, and team members understand their role in protecting vulnerable people.

Inspector's evidence

Standard Operating Procedures (SOPs) were up to date. Members of the team had read SOPs relevant to their roles and were in the process of reading updated SOPs which covered the management of controlled drugs (CD). Team roles were defined within the SOPs.

Near misses were recorded on a log and were reviewed monthly. These were observed to be consistently recorded. Team members were encouraged to record their own mistakes. At the end of each month the pharmacy technician carried out a review of all near misses and dispensing incidents as part of the Patient Safety review to identify any patterns. This was done alongside the regular pharmacists and was also looked at by the store manager. Following past reviews medicines were moved on the shelves. The team had also stuck 'Select and Speak it' labels on the shelves, team members were required to say the name of the medicine when picking these to reduce the risk of error. The pharmacy team were due to go live on the new system 'Columbus' they anticipated that this would reduce the number of picking errors as medicines had to be scanned before they were labelled. The pharmacy technician checked to see that colleagues were recording near misses and ensured that team members were up-to-date with SOPs.

Each month the team also read and signed the Professional Standards bulletin which was sent by the superintendent and also covered learning from errors. Following a near miss the team had moved quinine and quetiapine on the shelves.

Dispensing incidents were reported on an internal system 'PIERS' which automatically submitted a form to the head office team. This was then sent to the store manager who investigated the incident. As a result of an error where a medication dispensed at the hub was handed out to another person as team members had attached the wrong prescription to the bag. The team had reviewed how they processed received orders and changed the way in which prescriptions were reconciled with the dispensed medicines.

The correct responsible pharmacist (RP) notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance.

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. In-store complaints were handled by the RP or store manager who would try and resolve them. As a result of previous feedback on the queuing system the pharmacy had introduced signs and

measures to help manage this. The store manager used feedback and occasions where things had gone wrong as learning and to identify what could be changed.

Records for private prescriptions, emergency supply, unlicensed specials and controlled drug (CD) registers were well maintained. RP records were generally well maintained but the RP had signed out ahead of time. 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 (GDPR). Team members who accessed NHS systems had individual smartcards and passwords. The pharmacists had access to Summary Care Records and consent was gained verbally.

The team had completed safeguarding training on the e-learning system; in addition to this the pharmacists and technician had also completed the level 2 training. Details for the local safeguarding boards were available and displayed on a poster in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy was covered by a relief pharmacist and a pharmacy technician. A dispenser was due to start their shift during the course of the inspection. Another dispenser who worked part-time was on holiday. Other than on Thursdays and the weekend the pharmacy had two pharmacists working each day. On Thursdays the pharmacist would take a short break. Relief cover for dispensers was only provided for full-time staff. The store manager was a trained dispenser and helped the team out when they were short or needed help. The store managers had modelled the staffing in a way so that team members who worked on the healthcare side were trained pharmacy advisors so that they could also help in the dispensary when needed. Initially at the start of the inspection the dispensary had only been covered by the technician and pharmacist. However, through the course of the inspection as other team members started their shifts the team were seen to be better able to manage the workflow.

Staff performance was managed by the store manager who held informal quarterly reviews with all team members. He checked to see how team members were doing asking the RP for feedback. An annual formal review was also completed. Performance improvement plans were used where needed. The store manager provided team members with feedback as and when things were picked up and identified. As part of the pharmacists review a discussion was held as to what was expected of them and what the NHS requirements were.

The dispenser counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. He was aware of the maximum quantities of some medicines that could be sold over the counter. He was aware of the change in guidance for dispensing sodium valproate and was able to describe medicines which were contraindicated in certain conditions.

The store manager had identified that a team member completing their formal training course had started falling behind as someone had left. The trainee had sat down with their tutor and made a plan on how the training could be completed. The trainee had completed the theory part of the course and needed to complete the practical side of the training and had been allocated dedicated time in the dispensary to complete this.

The team were provided with regular training modules on e-learning which covered a range of different topics and areas and included ’30 minute tutors’. In addition to this team members also completed quarterly health and safety modules. The team members were provided with training time in store to complete their training. Pharmacists attended training session. ‘Let’s Connect’ days were attended by the store manager and pharmacists; these days also had sessions for CPD. The last one event had covered mental health issues and dementia. The store manager described that topics covered at the event tried to relate and match what was happening in the real world. The pharmacy technician was supported by the manager and pharmacist to complete his CPD.

As there was not much space in the dispensary instead of holding meetings, the store manager held regular conversations with the team to discuss priorities for the day, training plans. The manager worked across all days so was able to catch up with all the team members. The team also had a group chat on an electronic messaging application. Team members said that they were able to give feedback and suggestions. The security guard had been reinstated by higher management following feedback provided.

As well as receiving the monthly Professional Standards bulletins the team received alerts on Boots Live (the company intranet). This could be accessed by the store manager, RP and another team member. Boots Live was used to communicate tasks, alerts, and gave dates by when things needed to be done and who needed to do it. The team discussed things as they came up.

Numerical targets were set for services provided. These were set on a weekly basis. The relief pharmacist was usually briefed by the manager on what they needed to try and achieve. The RP said that these did not affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are largely clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was in the main clean, although some areas were worn down. It was suitable for the provision of healthcare. Workbench space was allocated for specific tasks. Multi-compartment compliance packs were prepared in a dedicated area in the stock room. Cleaning was done by the team with a rota in place and a contracted cleaner also came in. Medicines were arranged neatly. A clean sink was available.

There was a clearly signposted consultation room available for people to have private conversations. People could have conversations inside which would not be overheard. The consultation room was clean and tidy. The room was locked when not in use Information containing people's personal details was found in the room along with some prescription-only medicines (POMS), these were removed by the store manager during the inspection.

Following previous feedback, the pharmacy had implemented a queuing system for people using the pharmacy counter to ensure that confidentiality was maintained when someone was talking to a team member or pharmacist.

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 regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street with wide step-free entrance and power assisted doors. There was easy access to the medicines counter. The pharmacy had the facilities to increase font size when printing labels. And it had a hearing loop. Team members were aware of the need to sign post people to other providers if a service was not available at the pharmacy and said that they would use the internet if they were not familiar with a particular service. Team members were multilingual or would use translation applications.

The RP and store manager felt that the flu vaccination service and Medicines Use Reviews (MUR) had the most impact on the local population. Most people using the pharmacy were older and their medicines changed frequently, through the service the team were able to help and support them. The RP was not accredited to provide the hair retention service and would ask the person to come back on a day when the accredited pharmacists were working.

Approximately 70% of the pharmacy's repeat prescriptions were sent to the hub 'DSP' to be dispensed. The pharmacy had a dedicated workstation used for the service. Prescriptions were entered onto the system by a dispenser after which the pharmacist completed a clinical check. These were sent off and received two working days later. Prescription forms were retained in the pharmacy and matched to the dispensed medication once received. The RP opened bags and checked them prior to handing them out. Certain medicines including liquid preparations, CDs, certain creams, dressings, bulky items and fridge lines were not dispensed at the hub. The pharmacy had an option to dispense the prescription locally if needed.

The pharmacy had an established workflow. Prescriptions were taken in at an allocated counter and dispensed by one of the dispensers. Pharmacist Information Forms (PIFs) were filled out at the point of labelling. This had information relating to allergies, interactions, eligibility for services or any other information the team member wished to relay. Warning laminates were also placed with high-risk drugs and those where pharmacist intervention was required. PIF forms were not observed to be used for all prescriptions. Laminates for high-risk medicines had question prompts at the back which reminded the team member on what to ask people when handing out their prescriptions. Prescriptions were checked by the pharmacist once they had been dispensed. The RP very rarely had to self-check. 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 used tubs to ensure that people's prescriptions were separated. Due to the formatting on the labels the date of dispensing was seen to be cut off on a number of dispensed medicines. This was discussed with the team.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated

Pregnancy Prevention Programme. Team members would refer anyone in the at-risk group to the pharmacist and used cards and warning labels.

When dispensing other high-risk medications, the RP and dispenser said that the warning cards were used. For warfarin prescriptions the RP checked the yellow book and the was recorded on the patient medication record (PMR). Signed and on date patient group directions were in place for the services provided.

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 with the date set when the person collected their medicines. 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. If someone was admitted into hospital, the team were made aware by either the hospital or the person's representative. No medication was dispensed until the person was discharged and the pharmacy were notified. Team members informed the person's GP and any changed were updated. Packs were prepared and sealed after which they were checked by the RP. Prescriptions were clinically checked before packs were prepared. Packs were prepared upstairs in an allocated area.

From time to time team members checked if the multi-compartment compliance pack service was appropriate for people. They had recently reviewed people to see if they needed the service and a number of people (four to five) were identified who were able to switch back to original packs. The team carried out ongoing checks to see if these people were managing ok. The team had built good relations with people and their carers.

Assembled packs 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.

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 team were unsure if they were compliant with the Falsified Medicines Directive (FMD). They scanned barcodes as part of the dispensing process.

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. Due to the regular weekend dispenser being on holiday the matrix had not been updated in the last two weeks.Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

Drug recalls were received via alerts from Boots Live or via fax. The RP printed these out and they were signed and dated to show what action had been taken. The last alert for which some action had to be taken was for ranitidine.

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 calibrated measures available. Tablet counting trays were available. Separate measures were marked for methadone use only and 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.