General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 191 Haverstock Hill, LONDON, NW3 4QG

Pharmacy reference: 1040574

Type of pharmacy: Community

Date of inspection: 09/10/2019

Pharmacy context

The pharmacy is located in a parade of businesses in a residential area near the Royal Free Hospital. 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 prescription collection, substance misuse and seasonal flu vaccination. 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 risks associated with provision of services are identified and managed.
		1.2	Good practice	The safety and quality of pharmacy services are constantly reviewed and monitored.
2. Staff	Standards met	2.2	Good practice	Staff learning and development are supported and encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	People with a wide range of needs can access the pharmacy's services.
		4.2	Good practice	The pharmacy team manages and delivers the pharmacy's services safely and effectively.
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 team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk well and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed and the patient safety review was in progress. Staff said the number of near misses were reducing due to the new Columbus computer system. The prescription was scanned to generate patient and prescription image. If the incorrect item was picked and scanned, a warning message appeared on the screen. Staff explained that care was taken to check the dose and any alerts.

The Professional Standard (PS) was read and signed by staff and included information on the flu vaccination service and updates on adrenalin injection devices which would be needed for the resuscitation kit for flu vaccination service. There was a case study regarding missed medicines in a care home setting and POM to P information about Otrivine Extra Dual Relief nasal spray. There was a serious shortage protocol (SSP) to be read by staff.

'Lookalike, soundalike' (LASA) medicines laminates and 'select and speak it' alert labels were displayed to reduce picking errors. Some high-risk medicines such as different strengths of warfarin were stored in labelled boxes on the dispensary shelves. A model day poster provided a visual guide to managing daily dispensary tasks. Both dispensers were patient safety champions responsible for preparing owing medicines, tracking due dates for managed repeat prescriptions and managing tasks for the day to ensure tasks were managed safely throughout the day.

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 and four-way stamp 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 medicines, owing medicines, interactions. 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.

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. 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. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid.

There was a folder of information and each patient had their own polythene sleeve containing their discharge summaries, Medisure patient record and carer collection record sheet. When the discharge summary was received at the pharmacy following a hospital stay, the pharmacist checked the surgery had a copy and any changes were made to the prescription.

Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of blister packs. Some high-risk medicines such as alendronate were supplied separately in the compliance aid. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. Lansoprazole was 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 questionnaire was being conducted at the time of the visit. The staff were up-to-date with training in standard operating procedures (SOPs) at the time of the visit. The latest SOPs related to SSP. The medicines counter assistant 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. Hydrocortisone cream would not be sold for use on the face. When asked for a specific product, staff followed the 'CARE' pathway to ensure the medication was suitable to treat the condition.

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, emergency and special supplies were complete and the patient group direction (PGD) to administer flu vaccination was in date.

The CD and methadone registers were mostly complete, and the balance of CDs was audited weekly in line with the SOP. Some headers in the methadone register required completion. A random check of the actual stock of two strengths of modified release morphine medication reconciled with the recorded balance in the CD registers. Footnotes correcting entries were signed and dated. 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 training and there were safeguarding posters displaying safeguarding information and contact details for Boots and Camden NHS to report concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and works well together. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time and one part-time pharmacist, one relief pharmacist, one full-time and one part-time dispenser also accredited as medicines counter assistants and one full-time medicines counter assistant.

Staff had their own log-in details and were provided with ongoing training appropriate to their role via eLearning. The current tutor pack included topics such as Nytol and menopause. Staff were required to read PS which included topics on drug of the month, children's medicines and ensuring the age of the child was recorded on prescriptions and reviewed procedure to transfer medicines to the patient and initial the bag label to show who accuracy checked and who handed out the medicines to the patient. The pharmacist had completed pharmacist independent prescriber (PIP) training specialising in type 2 diabetes. The pharmacist was to be involved in a pilot service as a PIP for minor illnesses including constipation, otitis media and sore throat.

Staff were due to have a performance review. There was a whistleblowing policy and a poster supporting staff to raise concerns. Staff felt able to provide feedback and had suggested designing and recording an improved audit trail of when the carer was due to collect compliance aids and therefore when they should be prepared ready for collection. 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. There is a consultation room where people can have a private conversation with the pharmacist.

Inspector's evidence

The pharmacy premises have older fixtures and fittings but are generally clean. The dispensary sink required treatment to remove lime-scale. The lavatory facilities were generally clean and handwashing equipment was provided. The consultation room was in the corner at the front of the retail area of the pharmacy. It was usually locked and protected patient privacy. The consultation room was clean and tidy and presented a professional image. The sharps bin was located under the desk. There were posters regarding dealing with needle stick injury and anaphylaxis and health related leaflets. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was wheelchair access via a power assisted door and a seating area for waiting patients. There was a hearing loop to assist hearing impaired people and large font labels could be printed to assist visually impaired patients. Staff could converse in Bengali, Arabic, Hindi, Kurdish, Portuguese and Gujarati to assist patients whose first language was not English. Staff name badges showed the flag of the country whose language could be spoken. Patients were signposted to other local services including optician, Royal Free Hospital, a private clinic, NHS 111, walk-in centre and records were kept of signposting events in the pharmacy duty folder.

There were no patients in the at-risk group at the time of the visit, but the pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) would be explained. The intervention was recorded on the patient medication record (PMR). There was a sodium valproate poster for staff reference in the dispensary. The prescriber would be contacted regarding 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.

The pharmacist said that when supplying warfarin and in line with the questions on the reverse of the warfarin laminated card, people where 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. 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.

Audits had been conducted to identify people for referral for prescription of proton pump inhibitor for gastric protection during the non-steroidal anti-inflammatory drug (NSAID) audit. The audit regarding use of inhalers in asthma had been conducted and both phases of the sodium valproate audit. In the health zone there were posters to increase public awareness on display relating to malaria protection, dementia friends, type 2 diabetes and Stoptober. To meet quality payments criteria, staff had previously completed children's oral health and risk management training. Currently staff training included safeguarding, sepsis and LASA medicines.

Medicines and medical devices were obtained from Alliance, Phoenix, NWOS and AAH. Floor areas were mostly clear, and stock was stored on the dispensary shelves. Stock was date checked, recorded and filed in the patient safety folder. Short-dated stock was highlighted. 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 the medical fridge. Uncollected prescriptions were cleared from retrieval every four weeks after the patient had been contacted. If prescriptions were not collected, the reason was recorded on the PMR. 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 not operational at the time of the visit. Drug alerts and recalls were actioned, annotated and filed in the patient safety folder.

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's equipment keeps people's private information safe.

Inspector's evidence

Current reference sources included BNF. The dispensary sink required treatment to remove lime-scale. There were standard glass measures to measure liquids including separate marked measure for methadone. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius and recorded in the pharmacy duty folder. The CD cabinet was fixed with bolts. There was a sharps bin for vaccination sharps disposal and two in-date adrenalin injection devices for use in the event of anaphylaxis. 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.

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.