General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 14 Harben Parade, Finchley Road, Swiss Cottage, LONDON, NW3 6JP

Pharmacy reference: 1040575

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

This is a community pharmacy located along a parade of shops in North West London. A range of people use the pharmacy's services. The pharmacy dispenses NHS and private prescriptions. It offers services such as Medicines Use Reviews (MURs), the New Medicines Service (NMS), seasonal flu vaccinations, malaria prophylaxis as well as travel vaccinations. And, it supplies some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time. The pharmacy also provides an off-site dispensing service where some medicines are assembled elsewhere and delivered back to the branch for people to collect.

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	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 identifies and manages most risks effectively. Members of the pharmacy team monitor the safety of their services by recording mistakes and learning from these. But, the pharmacy does not display information about how people can complain about the pharmacy. This makes it harder for people to know who to raise concerns with and could mean that the pharmacy misses opportunities to improve its services. Team members understand how they can protect the welfare of vulnerable people. And, the pharmacy generally keeps most records in accordance with the law. But, it doesn't always include all the details of private prescriptions in its records. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy held a range of documented Standard Operating Procedures (SOPs) to cover the services that it provided. Roles and responsibilities of the team were defined within these and staff declarations were complete to state that they had read SOPs. The correct Responsible Pharmacist (RP) notice was on display and this provided details of the pharmacist in charge of operational activities, on the day.

The team attached the company's Patient Information Forms (PIFs) to all prescriptions so that relevant information could be easily identified. This included forms for the Monitored Dosage Systems (MDS).

Staff explained that most of the workload was dispensed on the front workstations. The RP accuracy-checked prescriptions at the back or brought these out to check and counsel people at the same time. The team provided realistic waiting times to assist with reducing risks and described asking people to step back if they were leaning over the workstation. This helped them to manage distractions and protect people's private information when they worked.

Staff routinely recorded their near misses and a separate sheet was used to monitor near misses involved with MDS. Near misses were collectively reviewed every month and three members of the team were described as taking responsibility for this. The company's Patient Safety Review (PSR) was used to assist with the review and the team was briefed about common mistakes every month.

Trends/patterns seen involved ensuring the packaging was routinely crossed if split packs occurred, that dosage instructions were not left abbreviated when generating labels (such as changing 'prn' to 'when required') and making sure that look-alike and sound-alike (LASA) medicines were highlighted on PIFs. Team members explained that the pharmacy's stock had been recently moved around and re-arranged so that extra space was created, and medicines were easier to select.

Incidents were handled by pharmacists and the procedure involved gathering relevant information, apologising, rectifying, documenting details on the company's system and investigating. If incorrect medication was taken, the prescriber was informed. At the point of inspection, there was no information on display in the retail area to inform people about the pharmacy's complaints procedure. The pharmacy's practice leaflet was seen in the consultation room, but this was locked. This meant that people could not easily access this information.

There was also no information on display to inform people that their medicines were being dispensed off-site. The RP explained that people who were new to the company's services were explained the

process verbally, unless people physically opted out of the service then the company could provide this service and that there was an option under the electronic prescription nomination for people to opt-out of the off-site dispensing service if they wanted this.

There was no confidential information left in areas that were accessible to the public. Sensitive details from dispensed prescriptions awaiting collection were not visible from the front counter. Confidential waste was segregated into separate designated bins and disposed of through company procedures and staff had completed the company information governance e-learning training. They were trained on the EU General Data Protection Regulation (GDPR) and there was a notice on display to inform people about how the pharmacy maintained their privacy. Summary Care Records were accessed by the RP for queries and consent was obtained verbally for this.

One person's NHS smart card to access electronic prescription was left within a computer terminal. The inspection occurred first thing in the morning and this member of staff was not on the premises at the time. After the inspector highlighted this, the card was removed. Staff explained that they normally took their cards home overnight.

Staff could identify groups of people that required safeguarding and identify signs of concern. In the event of a concern, the RP would be informed. They had read SOPs and completed training through e-learning. The procedure to follow with relevant and local contact details were present and the RP was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE).

The RP record was complete although over-written entries and the odd crossed out entry was seen without an appropriate amendment being made. A sample of registers for Controlled Drugs (CDs), records of unlicensed medicines and emergency supplies were maintained in line with statutory requirements. Balances for CDs were checked and documented every week. On randomly selecting some CDs that were held (Ritalin, Morphgesic and Oxynorm), their quantities corresponded to the balances stated in registers.

The minimum and maximum temperature of the fridge was routinely monitored. This helped to ensure medicines that required cold storage were appropriately stored and records were maintained every day to verify this. The pharmacy maintained a complete record for the receipt and destruction of CDs that were returned by the public. There were incorrect prescriber details recorded for some entries within the electronic private prescription register. Professional indemnity insurance arrangements for the provision of pharmacy services were in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are trained well. They have a sound understanding of their roles and responsibilities. The team are provided with resources to keep their skills and knowledge up to date. And, their progress is regularly monitored to identify opportunities for them to develop or learn.

Inspector's evidence

The pharmacy dispensed 4,000 prescription items every month with 90-100 people receiving MDS trays and 20 people with instalment prescriptions. Staff present included a relief pharmacist and two trained dispensing assistants, one of whom was undertaking accredited training for the NVQ3 in dispensing and the other was involved with dispensing MDS trays downstairs. The assistant manager was healthcare trained and demonstrated a high level of knowledge of over-the-counter medicines, she used suitable sales of medicines protocols before medicines were sold and referred appropriately to the RP when needed. Another trained dispensing assistant was due in later in the morning, the store manager was trained as a dispensing assistant and there was also a regular store-based pharmacist. Staff wore name badges outlining their roles. Certificates to demonstrate qualifications obtained were not seen.

Team members in training described completing course material at home and at work. For the latter, the time was protected. The company provided staff with e-learning, newsletters, tutor packs and the team took instruction from the pharmacists to help keep their knowledge current. Staff progress was checked periodically as well as formally every three months. Some team members explained that they were encouraged to further develop their role and complete ongoing, accredited training by the management team. The RP described a target to achieve 400 MURs annually that was manageable and achievable. There was no pressure applied to achieve this, according to her.

Principle 3 - Premises ✔ Standards met

Summary findings

In general, the pharmacy premises are clean, secure and provide a professional environment for the delivery of pharmacy services.

Inspector's evidence

The pharmacy consisted of a medium sized retail area and a dispensary that was located on the right-hand side of the entrance. There was plenty of space for dispensing activity to occur and a separate dispensary was in the basement, in the stock room. This was used to assemble and store MDS trays. This section was kept locked when not in use.

There was also a hatch in the dispensary where supervised consumption occurred. At the point of inspection, this was not opened and used but there was confidential information (such as plastic tubs with prescriptions and dispensed medicines) present in the area. The pharmacist explained that the area was usually kept clear and this would be cleared before use.

A signposted consultation room was available for services and private conversations. The door was kept locked. The room was of an ample size for services and there was no confidential information easily accessible.

The pharmacy was clean, it was suitably lit, well-presented and ventilated. There was key coded access into staff areas and Pharmacy only (P) medicines were stored behind the front pharmacy counter. Staff were always within the vicinity to help prevent these medicines from being self-selected and a barrier was present on one side of the counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable sources. But, it mixes some batches of medicines and stores some medicines in poorly labelled containers. This makes it harder for the team to check the expiry date, assess the stability or take any necessary action if the medicine is recalled. In general, the pharmacy provides its services safely and effectively. And, the team takes extra care with people receiving higher-risk medicines. This helps to ensure that people can take their medicines safely. But, team members may not always be disposing of people's private information appropriately.

Inspector's evidence

There was an automatic door at the front of the store and entry into the pharmacy was at street level. This, coupled with the wide aisles and clear, open spaces inside the pharmacy, enabled people requiring wheelchair access to easily use the pharmacy. Two seats were available for people waiting for prescriptions. Staff described using the hearing aid loop, speaking clearly for people who were partially deaf, and/or they would take them to the consultation room to maintain their privacy if needed. Physical assistance was provided, if required for people who were partially sighted and members of the pharmacy team spoke Urdu, French, Hindi, Bengali and Arabic to help communicate with people whose first language was not English.

In addition to the Essential Services, the pharmacy also provided medicines under private Patient Group Directions (PGDs) for hair retention, malaria chemoprophylaxis and administered vaccinations for chicken pox as well as for travelling. The latter included yellow fever vaccinations. The RP on the day was not accredited to provide the vaccinations and the pharmacy operated an appointment-based system. PGD information and SOPs for the services provided were seen, they were signed by authorised pharmacists.

Plastic tubs were used to hold prescriptions and items, and this helped prevent their inadvertent transfer during the dispensing process. A dispensing audit trail from a facility on generated labels as well as a quad stamp assisted in identifying staff involved.

Prescriptions for people prescribed higher risk medicines were identified using laminated cards. Staff routinely checked and recorded relevant information. This included asking about the dose, strength and blood test results such as the International Normalised Ratio (INR) levels for people prescribed warfarin. Staff were aware of risks associated for females who may become pregnant that were prescribed valproate. Relevant material was present to provide to them upon supply. An audit had been completed and no females at risk, had been supplied this medicine, according to staff.

Dispensed prescriptions awaiting collection were stored within an alphabetical retrieval system. The team used laminated cards to highlight relevant information such as CDs (Schedules 2-3), fridge and higher-risk medicines. Staff placed fridge and CD items into clear bags once they were assembled, this helped to identify them more easily when they were handed out. Staff described trying to check uncollected prescriptions every week and used a text messaging system to help assist people in collecting their medicines. Schedule 4 CDs were not identified using any means (PIFs, laminates or stickers).

Off-site dispensing: The process involved triaging prescriptions to remove those that had CDs, fridge

lines, bulky medicines or antibiotics that required reconstitution as these prescriptions were dispensed on-site. The remaining prescriptions were then dispensed through the pharmacy's system and the details transmitted to the dispensing support pharmacy (DSP) in Preston. Physical prescriptions were held at the pharmacy. Dispensed prescriptions were sent back from the DSP in orange totes two days later, and staff matched bags to prescriptions at this point. The RP explained that it was indicated on the bag if there were any items that were missing, and these were then dispensed at the pharmacy.

MDS trays were initiated after liaising with the person's GP, if people were struggling to take their medicines on time. The pharmacy ordered prescriptions on behalf of people. Staff cross-referenced details on prescriptions against individual records held for people. This helped them to identify changes and records were maintained to verify that this occurred. All medicines were de-blistered into trays with none supplied within their outer packaging. Trays were not left unsealed overnight when assembled. Descriptions of medicines were provided and Patient Information Leaflets (PILs) were routinely supplied. People prescribed warfarin and finasteride who received trays were supplied these medicines separately and INR levels were routinely obtained for the former. Details about this were seen documented. Mid-cycle changes involved either new trays being supplied, or trays being retrieved, amended and re-checked before being re-supplied.

Medicines were delivered through the company's PDC system. The pharmacy maintained audit trails to verify when and where medicines were delivered, this included highlighting CDs and fridge items as well as using separate sheets to record details of the former. The company's drivers obtained signatures from people when they were in receipt of their medicines. Staff described calling people before deliveries occurred, this minimised failed delivery happening. If this occurred, medicines were brought back to the branch with notes left to inform people about the attempt made and medicines were not left unattended.

The pharmacy used licensed wholesalers such as Alliance Healthcare, AAH and Phoenix to obtain medicines and medical devices. Unlicensed medicines were received from Alliance Specials. Other than the pharmacist, staff were unaware about processes involved for the European Falsified Medicines Directive (FMD). There was no relevant equipment on site or guidance information present for the team and the pharmacy was not complying with FMD at the point of inspection.

Medicines were date-checked for expiry every week and there was a date-checking schedule in place to demonstrate that this had occurred. Staff used stickers to highlight short dated items. There were no date-expired medicines seen. Liquid medicines were marked with the date they were opened onto their packaging. CDs were stored under safe custody and pharmacists maintained the keys to the cabinet in a manner that prevented unauthorised access during the day as well as overnight. A CD key log was completed as an audit trail to demonstrate this. Some mixed batches were seen and a few poorly labelled containers where the batch number and expiry date of the medicine was not annotated onto the packaging.

Medicines brought back by the public that required disposal, were accepted by staff, appropriate containers were present to store these, and they were collected in line with contractual arrangements. People bringing back sharps to be disposed of were accepted provided they were in sealed bins. However, instead of disposing of some rubbish in the normal waste bin, this was seen inside the bin used to dispose of sharps. The bin also contained people's confidential information that had not been appropriately destroyed. Returned CDs were brought to the attention of the RP and segregated in the CD cabinet before their destruction. Relevant details were entered into a CD returns register.

Drug alerts were received through the company system. The team checked for affected stock and acted as necessary. An audit trail was present to demonstrate the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities to provide its services safely.

Inspector's evidence

The pharmacy held current versions of reference sources. The CD cabinets conformed to legal requirements and the medical fridges were operating at appropriate temperatures. There were clean, crown stamped, conical measures available for liquid medicines as well as designated ones for methadone. Counting triangles were present with a separate one for cytotoxic medicines.

The sink in the dispensary used to reconstitute medicines was clean. Antibacterial hand wash and hot and cold running water was available. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. Staff could store their belongings in lockers.

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.