General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 40 Hampstead High Street, Hampstead, LONDON, NW3 1QE

Pharmacy reference: 1040576

Type of pharmacy: Community

Date of inspection: 26/11/2019

Pharmacy context

The pharmacy is located on a busy high street in a residential area in Hampstead. 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 malaria prophylaxis. The pharmacy has healthy living status.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 identifies and manages risks associated with the provision of its services.
		1.2	Good practice	The pharmacy reviews and monitors the safety and quality of its services.
2. Staff	Standards met	2.2	Good practice	Staff development and learning is supported.
		2.5	Good practice	Staff are encouraged to provide feedback to improve services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy's services are accessible to people with a range of needs.
		4.2	Good practice	The pharmacy delivers its 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, and it manages risk well. The pharmacy 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 keep people's information secure.

Inspector's evidence

Near misses were recorded and reviewed and the patient safety champion discussed any trends identified with staff at a monthly meeting. Staff said the number of near misses had decreased 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. 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. An action point in the patient safety review was to ensure LASA medicines were highlighted on the pharmacist information form (PIF), check dose of paediatric prescriptions and double check quantities when assembling a prescription. There was a patient safety folder which included information to go through with staff on topics including antibiotics for children and accurate calculation of dose to be shown on the PIF. The accuracy checking tool was displayed for staff reference during dispensing and checking procedures. The Professional Standard (PS) issue for November was displayed, read and signed by staff. It included information on the procedure for allergy not being followed during administration of a flu vaccination. The 'model day' poster assisted staff in managing time by completing tasks at certain times of 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. The four-way stamp was initialled to identify staff involved in dispensing, checking and handing out of medication. Special messages were recorded on the PIF including high-risk and LASA medicines, owing medicines and 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. The Columbus computer system ordered stock for the prescriptions which were then assembled for their due date and staff checked each day which people were due their prescriptions, so they were completed and ready to collect.

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 restricted space. Two or three compliance aids were prepared daily at a time

when it was quiet in the pharmacy. The matrix was signed by the dispenser when preparation was complete for a set of compliance aids. The pharmacy managed prescription re-ordering on behalf of patients and liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. A 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-written each time there was a change in medication. There was a communication book to record special messages relating to compliance aids such as when the patient was admitted to hospital. A record of the communication was retained with the prescription and a copy was filed with Medisure record once the action was completed.

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 and sodium valproate were generally supplied separately to the compliance aid. The dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine 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 questionnaires had been submitted at the time of the visit. Staff said feedback from members of the public usually related to expanding the premises. Members of the pharmacy team were up-to-date with training in standard operating procedures (SOPs) at the time of the visit. The latest SOPs related to serious shortage protocol and medicines use review and prescription intervention service. There was a patient safety briefing reminding staff to follow the SOP for dispensing for children and hand out (of prescriptions) SOP. The pharmacy advisor who served at the medicines counter said he would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. 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 ‘specials’ supplies were complete.

The CD and methadone registers were mostly complete, and the balance of CDs was audited weekly in line with the SOP. A random check of the actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were signed and dated. Invoice number and name but not always address of the supplier were recorded for receipt of CDs. 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 along with ‘Your data matters to the NHS’. 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 and one staff member was in the process of having her card unlocked. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training. The pharmacist had undertaken level 2 safeguarding via Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and works well together. They are actively encouraged to complete ongoing training. Pharmacy staff 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 two part-time pharmacists (who covered Sundays), relief pharmacists who covered Saturdays, one part-time registered pharmacy technician, one part-time trainee pharmacy technician, one full-time pharmacy advisor and one part-time newly recruited staff member who would be enrolled on pharmacy advisor training after completion of a probationary period. There was a vacancy for a part-time staff member.

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. The current tutor pack included topics such as restful sleep, age well and menopause. On completion of study there was a knowledge test. Staff were required to read PS which included topics on drug of the month and a case study. In line with the Pharmacy Quality Scheme (PQS) there was training in safeguarding, sepsis, reducing LASA errors and risk management.

Staff performance was monitored via annual appraisal and regular reviews. Feedback on staff received from members of the public was communicated to staff via 'Star of the Week'. Pharmacists and pharmacy technicians attended 'Let's Connect' events annually to meet with peers, be updated on company news and complete some continuing professional development. There were weekly pharmacy team meetings to discuss what was to be achieved in the coming week. Staff felt able to provide feedback on topics such as how another staff member had dealt with a member of the public or asked 'CARE' questions. The pharmacy advisor had suggested placing a stock order for an item for a person and arranging for home delivery to save them coming to the pharmacy. 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 small with one central shelf unit (gondola). Fixtures and fittings were older but generally clean. The dispensary was behind the medicines counter. It was small and narrow with limited bench space but well organised. The dispensary benches were kept clean and clear to free up valuable work space. There was no consultation room but patients could have a private word with the pharmacist if needed. Lavatory facilities were clean and handwashing equipment was provided. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. It knows what to do if any medicines or devices need to be returned to the suppliers. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. 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 via a power assisted door and a hearing loop to assist hearing impaired people. Large font labels could be printed to assist visually impaired patients. Staff could converse in Albanian, Serbo-Croatian 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 doctors, optician, Royal Free Hospital and local pharmacies for a flu vaccination. There was a signposting folder of information and staff referred to Camden NHS website for other services. 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. There was a discussion regarding intervention for prescriptions for more than 30 days' supply of a CD as good practice. 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 PIF. 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 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 audits regarding use of inhalers in asthma in children and adults had been conducted and both phases of the sodium valproate audit. Audits were planned for sodium valproate and monitoring diabetic patients regarding foot checks and retinopathy screening. In the health zone there were posters to increase public awareness on display relating to children's mental wellbeing, reducing taking antibiotics unnecessarily,

dementia friends, and Stoptober. To meet quality payments criteria, staff had previously completed children's oral health and risk management training.

Medicines and medical devices were obtained from Alliance and NWOS. Floor areas were mostly clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. 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. 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 and recorded on the pharmacy computer.

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 BNF and eBNF, EMC to locate and print PILs and Medicines Complete. The dispensary sink was clean and there was a range of stamped glass measures to measure liquids including a separate marked measure for methadone. 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. 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 and one staff member was in the process of having her card unlocked. 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.