General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 96-104 Eltham High Street, LONDON, SE9 1BW

Pharmacy reference: 1040804

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

This is a community pharmacy situated on a busy high street in South East London. Most of the people who use the pharmacy are older people. The pharmacy sells a wide range of over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids and provides flu and pneumonia vaccinations during the winter months.

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	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 generally manages the risks associated with its services. Members of the pharmacy team log any mistakes they make during the dispensing process and try to learn from these, but they may not always review dispensing incidents robustly. It generally keeps its records up to date to help show it provides services safely. It manages and protects confidential information well and it tells people how their private information will be used. People can give feedback about the pharmacy. The pharmacy uses this feedback to improve the services it provides. Team members understand how they can protect the welfare of vulnerable people.

Inspector's evidence

Members of the pharmacy team were asked to document near-misses as soon as they were identified. Near misses were reviewed at the end of every month to help identify any areas for improvement and a 'patient safety review' (PSR) form was completed. Team huddles were also held daily to discuss near-misses and incidents. Look alike, sound alike medicines, such as amlodipine and amitriptyline and azithromycin and azathioprine were now noted on pharmacist information forms (PIFs) to alert the pharmacist conducting a final check.

Members of the team were encouraged to read out loud the name of the medicine they had selected to help minimise picking errors. They were also briefed to place expiry date stickers on prescriptions for schedule 3 controlled drugs (CDs).

Dispensing incidents were recorded on the Boots online reporting system but there was little or no mention of them on the monthly PSRs, for example, there was no mention of the recent incident where the incorrect strength of a medicine was supplied to a person.

Tubs and trays were used throughout the dispensing process to prevent transfer of medicines between patients' prescriptions. Workbenches were kept clutter-free.

Up to date standard operating procedures (SOPs) were in place to support the safe and effective provision of services. Roles and responsibilities were outlined within each SOP and members of the pharmacy team had signed the relevant SOPs to confirm they had understood them. The pharmacist said that SOPs were re-read and re-signed annually by team members to help ensure they refreshed their knowledge on the processes.

In date indemnity insurance was in place. The responsible pharmacist (RP) sign was clearly displayed and samples of the RP record were complete.

Emergency supply records were held electronically; the nature of the emergency was not recorded for a number of entries checked. The private prescription record was generally complete but prescriber details and date on which the prescription was written were not always accurate. One undated private prescription for an antibiotic was seen to have been recently dispensed. 'Specials' records were completed in line with MHRA requirements.

CDs were stored in an organised manner. Stock was stored separately to other CDs such as those returned by people, expired medicines, and assembled substance misuse instalments. Running balance audits were conducted weekly; a random stock check of a CD medicine agreed with the recorded balance. A destruction register was available to document patient returned CDs and these were destroyed promptly. Date expired CDs were stored in a labelled tub and kept secure.

Customer feedback was sought via annual questionnaires and cards referring people to online feedback forms. The team had changed the chairs in the waiting area in response to some feedback about their appearance. The pharmacist had also informed people, including those receiving substance misuse treatment, of his lunchtime break to reduce their waiting time.

A consultation room was available for private conversations and services. Computers were password protected and access to the patient medication record (PMR) system was via individual Smart cards. Confidential waste was stored in blue waste bags which were collected daily by head office. Team members were all up to date on the company's e-Learning modules covering information governance, the General Data Protection Regulation and data protection; these were renewed annually. The privacy policy was displayed near the front counter for people to see.

All members of the team had completed the Boots annual e-learning module on safeguarding vulnerable groups. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module. Safeguarding contact details and guidance were displayed in the dispensary for the pharmacy team. There had not been any safeguarding incidents at the branch.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work in a supportive environment where they can raise concerns or make suggestions to improve the services. They are provided with some ongoing training. But they do not always have time set aside to do it. This may mean they do not always have opportunities to keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection there was a regular pharmacist, two dispensers (one was also the store manager) and a trainee dispenser (also an assistant manager). The pharmacy also employed a pre-registration student and another dispenser who mainly covered the medicines counter.

Staffing levels were reviewed at least once a year. Store management reviewed healthcare cover, items dispensed and services provided; there had not been much change in pharmacy staffing levels as management felt these were adequate.

The assistant manager, who had been enrolled onto the pharmacy advisor course, said he covered the medicines counter during lunch breaks or days off. He said he asked the WWHAM questions or followed the Boots Healthcare Pathway (when selling P medicines requested by name); he provided advice on how to use the product, what to avoid, length of treatment and when to seek additional medical advice. He described referring people to the pharmacist, for example children or those presenting with warning symptoms. He could name products which were open to abuse and was able to describe tasks which could not be carried out in the absence of the RP.

Members of the team felt they worked and communicated well together. Some members felt there was pressure to complete tasks in a timely manner, for example processing repeat orders, requesting repeat prescriptions and clearing the retrieval system. But they generally managed their workload and there was currently no backlog (there had been times where tasks were not completed in time due to staff shortages in the past).

Members of the team said that the store manager was very supportive and helped with tasks in the dispensary when needed.

Team huddles were held in the mornings to discuss any issues, errors, workload and actions to be taken by the team.

Team members had access to e-Learning modules and were provided time to complete the mandatory modules which were renewed annually. Some members of the team had not completed other additional training, such as the Boots ’30 minute tutor’ packs for several months and felt there were long intervals between training modules. The assistant manager said he read the Counter Intelligence booklets and other colleagues’ training course booklets.

Performance reviews were conducted twice a year or annually; members of the team were happy to raise concerns to the store manager or area manager and they were aware of the whistleblowing

policy. Members felt they were valued at work and were able to give feedback or make suggestions. Targets were set but some members of the team said it was at times difficult to meet these, however, the targets did not affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and the pharmacy provides a safe and secure environment for people to receive services.

Inspector's evidence

The dispensary was located at the back of the store and was clearly signposted. The pharmacy was cleaned daily by a cleaner. Fittings were well maintained. The dispensary was spacious and there was ample storage and work space; an island bench was fitted in the middle of the dispensary and was used to conduct accuracy checks.

A clean and tidy consultation room was available. The room was kept locked when not in use. The temperature was regulated by an air conditioning system and was suitable for the storage of medicines. There was good lighting throughout the premises. There was a clean sink available in the dispensary with hot and cold running water to allow for hand washing and preparation of medicines. Soap, hand sanitizer and paper towels were available. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy services. The pharmacy generally provides its services safely and effectively. But team members are not all aware of what advice to give people taking some higher risk medicines. This means that people might not get all the information they need to take their medicines safely. Medicines are well managed and appropriate action is taken where stock is not fit for purpose.

Inspector's evidence

Access was step-free and via an automatic door. There was sufficient space for wheelchairs and pushchairs in the retail area and a lowered worktop was fitted at the front counter to enable wheelchair users to sign their prescriptions. A hearing loop was available in the dispensary. And members of the team described signposting people to the consultation room for additional privacy. There were several chairs in the waiting area for customers wanting to wait for a service.

Team members said they contacted the doctor or used an online translation service if a person did not speak English well. Services were advertised in the practice leaflet and online. Team members said they verbally signposted people to services available at the pharmacy or to other pharmacies and healthcare providers.

Members of the team were observed confirming people's names and addresses before handing out dispensed medicines; this helped minimise hand out errors. The majority of prescriptions were received electronically; these were printed off in the morning and in the afternoon, labelled and clinically checked by the pharmacist in store. The prescriptions and labels were then sent to a hub (Dispensing Support Pharmacy, DSP) where the medicines were assembled. The dispensed medicines were accuracy checked by a pharmacist at the hub. Prescriptions for certain medicines were dispensed in store, for example, antibiotics, CDs and fridge items. Medicines were stored in plastic bags with a clear window to allow the pharmacist in store to conduct an additional check once they were received back. Labels were also annotated with number of bags for each person (for example 1 of 2) to ensure all medicines were supplied to the person. Any non-dispensed items were noted on the label for the pharmacy to then dispense in store. The pharmacy team were not entirely sure how they could identify who had checked the medicines at the hub, in case of a query or error.

Walk-in prescriptions were dispensed in store. Dispensing audit trails were seen to be maintained for these. People were sent text messages to remind them to collect their medication.

The retrieval system was cleared on a weekly basis to reduce clutter; prescriptions which were older than four weeks were removed and stored in alphabetical order should the person present at a later date. CD prescriptions were sent back to the prescriber.

Coloured stickers, annotated with the expiry date of the prescription, were placed on prescriptions for schedule 2 and 3 CDs. Prescriptions for Schedule 4 CDs were not routinely highlighted. This could increase the chance of these prescriptions being handed out after their expiry date. PIFs were used to highlight any changes or new medication. These were seen to be attached to prescriptions awaiting

collection.

Members of the team had read the valproate guidance, but some were not entirely sure of the checks to make, what information to provide, and how to label valproate removed from its original pack and supplied to patients who may become pregnant. Patient cards were available but additional warning stickers could not be found. An internal audit had been carried out by the pre-registration student to identify patients affected by the guidance, but members of the team were not sure of the results.

Coloured laminates were used to highlight higher risk medicines including methotrexate, lithium and warfarin. The pharmacist said he checked if people taking lithium were being monitored but this was normally during Medicines Use Reviews. He provided advice on medicines to avoid with lithium but could not describe side effects, signs of toxicity and dietary advice to provide them. People taking warfarin were asked to bring in their yellow book but INR levels were not always recorded on the PMR system, in line with the pharmacy's SOPs.

A 'Medisure progress log' was used to keep track of prescriptions ordered for people receiving multi-compartment compliance aids. However, the log was ticked to confirm that prescriptions had been ordered and processed but it was not dated to provide clear audit trails. Repeat requests were ordered seven days in advance; prescriptions were cross checked with individual record sheets once they were received. They were then labelled and sent to DSP who sent back the medicines in boxes. These were then assembled into compliance aids by the pharmacy team in store. Drug descriptions were provided and patient information leaflets (PILs) were supplied once a month.

Stock was obtained from reputable wholesalers and was stored tidily on the shelves. Expiry date checks were conducted on sections of the dispensary stock every week. Short-dated medicine was highlighted with a coloured sticker; no out of dates were found at the time of inspection.

The fridge temperatures were checked daily and kept within the required range of 2 to 8 degrees Celsius. CDs were kept securely. Drugs alerts and recalls were sent from head office via the intranet. These were printed out and signed. There was evidence that the pharmacy team had actioned recent alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services.

Inspector's evidence

The fridges were clean and suitable for the storage of medicines. Several clean, glass measures were available at the pharmacy, including separate measures for CDs. A blood pressure monitor was available; the store manager said that this was several months old. The pharmacy had tablet and capsule counters, with a separately marked counting triangle used for cytotoxic medicines.

Waste medicine bins and destruction kits were available to dispose of waste medicine and CDs respectively. These were stored securely. The team had access to the internet and up-to-date reference material.

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.