General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 30-31 Gloucester Arcade, 128 Gloucester Road, LONDON, SW7 4SF

Pharmacy reference: 1041067

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

This is a pharmacy located in a parade of shops on a busy high street in close proximity to an Underground Station. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also provides Medicines Use Reviews (MURs), New Medicine Service (NMS) and supplies emergency hormonal contraception (EHC).

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	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

Overall, the pharmacy largely manages the risks associated with its services. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members protect people's private information. And they know how to safeguard vulnerable people. When things go wrong, the pharmacy team responds well.

Inspector's evidence

Standard Operating Procedures (SOPs) were up to date. Members of the team had read SOPs relevant to their roles. Team roles were defined within the SOPs.

The trainee dispenser was the 'Patient Safety Champion'. A near miss log was stuck on the dispensary wall and this was observed to be consistently used. The trainee dispenser completed monthly patient safety reviews. At the time of the inspection they were in the process of completing the annual review. Through the reviews the team had identified that the most mistakes occurred between 3pm and 5pm. Team members had been asked to notify colleagues before they were due to finish their shift and that lunch breaks were covered. The trainee had also asked colleagues to check their work more thoroughly, particularly when dispensing 'look-alike, sound-alike' (LASA) medicines. Team members had also started giving people waiting times and notifying them if there was a wait as they had found that this had also led to an increase in mistakes. The dispensary team were briefed each month after the patient safety review was completed. A number of near misses observed to be recorded showed that the staffing levels had contributed to the mistake, the team had been trying to recruit for some time but had a large turnover and had not been able to fill the positions.
Each month the team also read and signed the Professional Standards bulletin which was sent by the superintendent and also covered learning from errors.

In the event that a dispensing incident was reported the RP would check if the person was ok and the incident was 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. The responsible pharmacist (RP) described that the appropriate SOP would be followed depending on the type of error. The RP would use the SOP, flowchart and store checklist to deal with any reports of errors. The error would be rectified, the team would be briefed and the RP would also check to see if team members involved in the incident were alright. As a result of an error in which a person was handed out two extra tablets, the team had contacted the person, informed the prescriber, checked that there was no harm, and the person had returned the extra medication.The error had occurred as the pharmacy had received a different brand which had a different pack size. The team had gone through and followed the SOP, and notified management and the Controlled Drug (CD) Accountable Officer. Following the incident steps were taken to ensure the pharmacists were not left working on their own and making sure that busy periods were covered. CDs were triple-checked and dispensers had been asked to double-check their own work. Quantities were also being counted with people as their medicines were handed out.

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, the RP tried to ensure that waiting times were clearly communicated to people and if it was going to take longer to make sure people were kept in the loop. The team tried to text everyone when their prescription was ready to collect and the patient information forms (PIF) forms were annotated if the contact number held for someone was incorrect so that they could be notified of the service and registered if needed.

Records for emergency supplies, RP records and controlled drug (CD) registers were well maintained. Private prescription records were generally well maintained but the date on the prescription was not always recorded correctly. Records for unlicensed medicines supplied could not be located, but the trainee dispenser was able to describe the records that he would keep. 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 the associated 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 had also completed the level 2 safeguarding training. Details for the local safeguarding boards were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an adequate number of staff to provide its services. It has fallen behind on its dispensing, but it is addressing this with support from other stores. And it is recruiting additional staff. Team members are given ongoing training. But they are not given time set aside for training. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy was having difficulty in recruiting and retaining team members. The team comprised of a trained weekend dispenser and one trainee dispensers (another trainee had resigned the week prior to the inspection). The vacancy had been advertised and the store manager was interviewing potential candidates. Another team member from the shop floor had been sent to another store to be trained and was due to return the week following the inspection. The pharmacy had lost three trained healthcare assistants and a full-time team member was on holiday at the time of the inspection. The store team was to be enrolled on the training so that they could cover the medicines counter when needed. The store manager was also a trained dispenser and helped out when needed.

The pharmacy had been running on locum and relief pharmacists as two of the store-based pharmacists had left earlier last year. Two new pharmacists had been recruited in September and October 2019.

The pharmacy was short staffed at the time of the inspection and team members said it had been difficult particularly over the last two weeks. The team were behind with their dispensing and the store-based pharmacist was working over-time to help catch up. She had tried to prioritise the workload and on the day of the inspection had caught up with the multi-compartment compliance packs. Team members said that they had been up-to-date two weeks prior to the visit. The team had been unable to get help from other nearby stores as they had also team members who were off work. Following the inspection, the clinical governance pharmacist gave assurances that additional support had been provided to the store to help them catch up. The store manager also confirmed, that the store had been provided with additional dispenser support and the team were now up-to-date with their workload. Two additional trainees had also been recruited to ensure that the team did not fall behind. Team members had also been provided with coaching. The pharmacy had also recruited another dispenser and would have two more dispensers working than on the day of the inspection.

The pharmacy had ongoing issues with staffing since the store manager had joined and had found it difficult to recruit support staff. At the time of the inspection the team had been approximately a week behind on dispensing their repeat prescriptions. Team members said that the pharmacy received a large number of walk-in prescriptions, this was observed during the inspection as there was a constant flow of people. The pharmacy had to cap the number of people who were supplied medicines in multi-compartment compliance packs and some packs (for about four people) were prepared at the store in Hammersmith and then handed out at the pharmacy. Consent had been gained from people before they had been transferred and prescriptions were kept at the Hammersmith branch. The pharmacist would call the Hammersmith branch if she noticed that someone did not have a record in store and had started putting a flag on the electronic record.

Staff performance was managed by the store manager, an initial set up conversation was held and a development plan was drawn up. At review meetings the team member and store manager discussed if

the team member was on track, performance and how they were doing, training carried out, competency levels and any tasks which were left to complete. If they were performing satisfactorily a discussion was held to see how the team member could be supported to excel or what needed to be improved.

The counter assistant 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.

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 store manager tried to provide team members with training time in-store to complete their training. However, over the past four months this had not routinely been happening due to staffing issues. Pharmacists attended training session. 'Let's Connect' days were attended by the store manager and pharmacists; these days also had sessions to support pharmacists with their Revalidation. Pharmacists also completed Centre for Pharmacy Postgraduate Education (CPPE) training and had completed training on sepsis, safeguarding and look-alike sound-alike medicines.

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, pharmacists and assistant manager. 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. Due to different shifts it was difficult to hold team meetings; the store manager or pharmacists discussed things with people as they started their shifts. The team used a communication diary and passed on messages via email or through colleagues. Team members said that the store manager was supportive and felt that they could approach him with any issues or concerns.

Targets were set for services provided such as MURs. Team members said that there was a 'normal' amount of pressure to meet the targets. The store manager did not apply pressure but checked with the team if they had done any consultations. A daily email flagged up if teams had fallen behind. The RP said that the targets did not affect her professional judgement. The store manager was aware of what was important and required in terms of feasibility.

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. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and tidy throughout but had not been updated for some time. There were a number of chairs situated away from the counter for people to use while they were waiting for their medication. Workbenches were cluttered with stock which was being put away and prescriptions waiting to be checked were stored on shelves. Most of the dispensing was done at the front counters. Multi-compartment compliance packs were prepared at the back after the bench had been tidied. Medicines were arranged on shelves and a sink was available for the preparation of medication. Cleaning was done by the team.

The consultation room was kept locked when not in use. The table could be folded away to allow better access for wheelchair users. There was a blind covering the window and low-level conversations could be held without being overheard. The computer was kept locked when not in use. There was a sink with hand washing facilities. The room was a bit dirty and there was some rubbish on the floor. The store manager gave assurances that he would ask the store cleaner to clean this room.

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 and blowers were brought in during the summer months as it could get warm.

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.

Inspector's evidence

There was step free access via one entrance and the other entrance had two steps. The doors to the store did not have assisted opening but there were team members on the shop floor who were able to assist people when needed. Team members were multilingual and had flags displayed on their name badges to indicate any other languages they spoke. The team also used translation applications. The pharmacy served a large number of people from other countries as it was situated near a university and different consulates. There were a variety of leaflets available in the shop and consultation room. Services and opening times were clearly advertised. Due to staffing issues the hair retention and travel vaccination services had been stopped. People wanting to access these services were referred to other nearby branches. Team members said that the priority at the time of the inspection was to concentrate on dispensing.

The pharmacist and store manager felt that the MUR and EHC service had the most impact on people locally. The pharmacy was the closest to the nearby university and team members went through the available options with people. People who had been using the pharmacy for a long time were generally older and taking lots of medicines. The pharmacist had found that there were a lot of people taking aspirin and anti-coagulants and she could use the opportunity to talk them through their medicines. The pharmacist described that some people were very thankful as no one had done that before. People also felt reassured and grateful due to the NMS follow-up call.

The pharmacy had an established workflow. Prescriptions were taken in and dispensed by one of the dispensers. Team members ensured that people were given an accurate waiting time. If stock was unavailable an order was placed whilst the person waited. 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. 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. The pharmacist tried to leave items dispensed on Saturday to be checked by the Sunday pharmacist. 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.

High-risk medicines were segregated on shelves and shelf edges were annotated with warning stickers. Team members placed a 'high-risk medicine' and 'refer to pharmacist' laminates in the tub at the point of dispensing and this was kept with the prescription until it was handed out. At the point of dispensing team members also checked to see if the person was eligible for an MUR. When supplying warfarin, the pharmacist checked the yellow book if it was available or verbally confirmed the INR with the person. A

record was made on the electronic recording system. The pharmacist was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. She had not seen any prescriptions for valproate for a person falling in the at-risk group. Prescriptions for all CDs had a 'CD' laminate placed with it and the date that the prescription expired was annotated on the PIF.

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. The service was managed by one of the dispensers who was away at the time of the inspection. Previously when the dispenser was on holiday the pharmacy would fall behind. The trainee dispenser was being trained to also help with the service. As the pharmacy had fallen behind with dispensing the packs the store-based pharmacist had been coming in early to catch up and another dispenser from a nearby store was due to come in on the day of the inspection to help out.

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. Packs were prepared and sealed after which they were checked by the RP. Prescriptions were clinically checked before packs were prepared. The dispenser usually called people if he noticed that someone had not collected their medication.

The pharmacy team had reviewed some people on the service to see if they still needed to have their medicines supplied in the multi-compartment compliance packs; they had not identified anyone who could be switched to original pack dispensing.

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 not compliant with the Falsified Medicines Directive (FMD). They were unsure as to when this was to be rolled out but were due to go live on the new electronic recording system 'Columbus' in April 2020.

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. The store manager checked to ensure team members completed checking the allocated section each week. 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. The store manager printed these out and notified the team. They were then signed and dated to show what action had been taken. The assistant manager and pharmacists were also able to check alerts. The system needed to be updated once an alert had been actioned. 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.