

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, Morden Hall Medical Centre, 256 Morden Road, LONDON, SW19 3DA

**Pharmacy reference:** 1041250

**Type of pharmacy:** Community

**Date of inspection:** 02/03/2020

## Pharmacy context

This is a small branch of Boots inside a busy medical centre opposite Morden Hall and within a short walk of Morden town centre. It is accredited as a Healthy Living Pharmacy (HLP). Its main activity is dispensing NHS prescriptions, mostly for people coming in from the medical centre. It also dispenses private prescriptions, sells a limited range of over-the-counter medicines and provides health advice. It offers a home delivery service for those who are unable to get to the pharmacy themselves.

## 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
<b>1. Governance</b>	Standards met	1.2	Good practice	Records of errors and near misses are regularly reviewed and records are kept showing what has been learned and what has been done.
<b>2. Staff</b>	Standards met	2.2	Good practice	Records show that staff complete regular ongoing training, relevant to their roles, to keep their skills and knowledge up to date. Their manager uses up-to-date reports to keep track of their progress, providing encouragement when appropriate.
		2.4	Good practice	The way in which team members were working efficiently and effectively together to manage their workload demonstrated very good teamwork and leadership
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy provides its services in line with clear, up-to-date processes and procedures which are being followed by its team members. They are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps good records of the mistakes that happen during the dispensing process. The pharmacist manager regularly reviews them with members of the team so that they can learn from them and avoid problems being repeated. The pharmacy manages and protects confidential information well and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy has adequate insurance in place to help protect people if things do go wrong.

### Inspector's evidence

There were Standard Operating Procedures (SOPs) in place to underpin all professional standards, seen as signed and read by staff. Several had been updated in November 2018 and due a review in November 2020 with others, notably the SOPs for controlled drugs (CDs) dated Nov 2019 and due to be reviewed in Nov 2021. Staff roles and responsibilities were all set out in a matrix within the SOP folder, and staff were all clear on the correct procedures to follow.

Errors and near misses were seen to be regularly recorded on a 'Near Miss Incident log' kept on a noticeboard in the dispensary. The responsible pharmacist (RP) who was the 'patient safety champion,' reviewed them with staff each week on a Monday, and then again on a Friday to include different members of staff. He also completed the 'Patient Safety Review' (PSR) every month for head office. A copy of the most recent review was attached to the dispensary wall for all staff to read. Actions agreed for the following month included checking that the 'no barcode' process was being followed. The RP explained that since they had introduced the new Columbus patient medication record (PMR) system they had seen a reduction in selection errors, so were now focussing on those items without a recognised barcode. These items were flagged to the pharmacist on the pharmacist information form (PIF) so that he would know that they had not been successfully scanned and therefore needed an extra check. They also highlighted 'Look Alike Sound Alike' (LASA) drugs on the PIF to help avoid picking errors. There were 'select and speak' signs on cartons adjacent to the LASAs as a prompt when picking those items. Some items which could be easily confused had been separated on the shelves, for example quetiapine products were on a different shelf to quinine products to minimise the risk of selecting the wrong product.

There was a business continuity plan in a red bag for staff to easily find, and the RP knew who to contact for advice in the event of an emergency. People working in the pharmacy were able to clearly explain what they do, what they were responsible for and when they might seek help. The RP log was seen to be complete and up to date. Staff were able to describe what action they would take in the absence of the responsible pharmacist, and they explained what they could and could not do. The responsible pharmacist notice was correct and clearly displayed for patients to see.

Results of the latest Community Pharmacy Patient Questionnaire (CPPQ) were not on display in the pharmacy but were available online. Results of the 2018/19 questionnaire showed that 93.2% of respondents rated the pharmacy as excellent or very good. Feedback included a need for somewhere

people could speak without being overheard. As a result of this the RP had encouraged his team to use the consultation room whenever possible. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display. It included contact details for the company's head office, Patient Advice and Liaison Service (PALS) and the Independent Complaint Advocacy Service. Credit card style prompt cards for seeking feedback were available at the prescription reception counter. A certificate of professional indemnity and public liability insurance from XL Insurance Co. Ltd was held electronically on the company's intranet.

Private prescription records were maintained electronically on the Patient Medication Record (PMR) system. A sample of records were checked, and all those inspected were complete with all the necessary details correctly recorded. Emergency supply records were also maintained electronically, complete with details of the emergency and a reason for supply. Several did not record the reason in enough detail, although the RP showed the inspector one particular entry of his which was very detailed. The required level of detail was discussed, and upon reflection the RP agreed to brief all of his team, including the relief pharmacists, to record more detailed reasons for emergency supplies. He did point out that they did not do many emergency supplies at the request of patients as he was normally able to signpost them to their GP for a prescription. The majority of emergency supplies were made at the request of the doctors in the medical centre as they had a very good working relationship.

The controlled drug (CD) register was seen to be correctly maintained, with all wholesaler addresses written in full. Running balances were checked weekly in accordance with the SOP. Stock balances of two random samples were checked and found to be correct. Amendments to the records were asterisked with a signed and dated footnote to identify who had made the amendment. Records of CDs returned by patients were seen to be made upon receipt and subsequent destruction documented and witnessed. Records of unlicensed 'specials' were present with most of the necessary information recorded. The prescriber details had not been completed on the certificates of conformity so the RP and ACT both agreed to ensure that they would be included in future. Access to the CD keys was recorded daily in the CD key log, stored within the pharmacy duty folder.

All staff were able to demonstrate an understanding of data protection and had undergone General Data Protection Regulation (GDPR) training. One of the pharmacy advisors explained that she knew not to leave dispensing labels or prescriptions lying around where people might see them. Confidential waste was kept separate from general waste and shredded offsite. There was a privacy notice on display for people to see. Completed prescriptions awaiting collection were stored in opaque drawers so they were not visible to those waiting at the counter.

There were safeguarding procedures in place and contact details of local referring agencies were in the safeguarding section of the pharmacy duty log. Contact details for children's safeguarding leads were also on a noticeboard, but not for vulnerable adults. The RP made a note to obtain a copy of the notice used by the medical centre and to display that. All registrants had been trained to level 2 and all other staff members had undergone level 1 Boots e-learning. Staff were able to describe some of the signs to look for and knew when to refer to the pharmacist. All staff were dementia friends.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy usually has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They work well together and can make suggestions to improve safety and workflows where appropriate

### Inspector's evidence

There was one pharmacy advisor, one registered accuracy checking technician (ACT) and the RP, on duty during the inspection. A second pharmacist arrived part way through the inspection to cover the end of the day. The size of the team appeared to be tight for the workload, although the RP did point out that two members of staff were currently off. In the event of staff shortages, they would adjust their working hours to cover each other. Normally they had sufficient staff to be able to send them to help other local branches. All staff wore badges showing their names and role.

Certificates to confirm staff qualifications were available both online and in paper files to show the levels of training completed. Ongoing training consisted of e-learning modules for staff to complete online. The RP demonstrated how he could track the progress of each staff member's training through a report available on his phone. There was also a selection of certificates from the Centre for Pharmacy Postgraduate Education (CPPE) in the Pharmacy Quality Scheme (PQS) folder verifying training recently undertaken by the pharmacy's registrants. Staff were able to demonstrate an awareness of potential medicines abuse and could identify patients making repeat purchases. All members of staff were seen to serve customers and asking appropriate questions when responding to requests or selling medicines.

The RP confirmed that he was comfortable with making decisions and did not feel pressurised to compromise his professional judgement. There were targets in place but they were applied sensibly. Team members were involved in open discussions about their mistakes and learning from them. Team members said that they could raise concerns and that there was a whistleblowing policy available for them if needed. The RP conducted periodic reviews with his team to discuss performance and areas for development. He explained how the company no longer used personal development plans but instead provided 'in the moment feedback' to let people know when they had done well or needed to improve.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. But they are small, so there isn't very much space for people to wait, especially when the pharmacy is busy. The premises include a private room which the team uses for some of its services and for private conversations.

### Inspector's evidence

There was step-free access into the pharmacy through a double doorway from the medical centre entrance. The premises were accessible to people with pushchairs or those with mobility issues, although space was limited. The pharmacy premises were small, but were clean, tidy and in a reasonable state of repair. There was a large dispensary which was well organised with separate assembly and checking areas. The workstations were kept reasonably tidy and free of clutter, although there was a stack of orange tote boxes containing assembled prescriptions from the dispensing support pharmacy (DSP) in Preston. The RP explained that the ACT would normally have checked through all of those and put them away by lunchtime. This had not been possible on this occasion owing to the temporary shortage of staff and the presence of the inspector. However, the ACT was able to deal with them during the course of the afternoon.

There was a small health promotion area with posters highlighting current local health priorities. There was a consultation room for confidential conversations, consultations and the provision of services. There was no confidential information on view inside the consultation room. There was a password-protected PMR computer and a closed sharps bin in the room. The door was kept closed when the room was not in use, and the RP felt that it was unlikely that anyone would gain access to the room without being seen by a member of staff.

The sink in the dispensary had a light coating of limescale owing to the hardness of the water locally. There was hot and cold running water and handwash available. Room temperatures were appropriately maintained by combined heating and air-conditioning units, keeping staff comfortable and suitable for the storage of medicines.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. But it only records some of the checks that it makes which may make it harder to show what had been done if a problem were to arise in the future.

### Inspector's evidence

There was a range of leaflets providing general health information and the services available from the pharmacy. The pharmacy provided a limited range of additional services as it focussed mainly on dispensing NHS prescriptions.

Controls were seen to be in place to reduce the risk of picking errors, such as highlighting LASAs on shelf with 'select & speak' labels. The RP explained how their new Columbus dispensing system also helped to prevent picking errors when the medicines were scanned as they were selected, and near misses had reduced accordingly. The team attached PIFs to each prescription token to communicate messages about the patient's medicines to the pharmacist. These were used to highlight new medicines, changes to their medicines, any allergies or whether the patient was eligible for further services, such as an MUR. The form also had a blank box to write any further information that the dispenser thought the pharmacist should be aware of, for example if the product had not been successfully scanned. There was also a selection of laminated prompt cards for specific types of prescription, for example those for babies and young children, or those for high-risk medicines such as warfarin. They prompted staff to check key safety information with the person collecting the prescription. They used baskets to keep individual prescriptions separate, and prescription labels were initialled to show who had dispensed and checked them. The system also endorsed the prescription tokens with prompts for the staff to sign showing who had labelled, clinically checked, assembled and completed the final check. Staff initialled the bag label on the finished prescriptions to complete the audit trail, signifying who had filled the bag and checked that it was complete and correctly labelled. The RP explained how they added an extra signature on the bag itself to indicate who had filed the completed prescription in the retrieval system. There was a separate signature to show who then handed the bag out to the patient. All of this helped to identify who had been involved at each stage in the process if any query arose after the prescription had been handed out.

Some of the pharmacy's prescriptions were dispensed offsite at the company's centralised DSP in Preston. The RP explained how the Columbus PMR system was able to automatically select those prescriptions to be assembled at the DSP, and those to be assembled onsite. He demonstrated how the tokens were separated into different groups, identifying those where something had changed since the previous supply and needing a further check by a pharmacist before assembly. He demonstrated the checking procedure used when the assembled prescriptions arrived back at the pharmacy and the audit trail showing who had been involved in each step of the process.



Owings tickets were in use when medicines could not be supplied in their entirety. The prescription was completed as soon as the missing item was back in stock. The RP explained how they checked stock availability every day through the Columbus system, and would obtain some of those items from other local branches if they had spare stock. If the item was likely to be unavailable for some time, or the patient was likely to run out, the pharmacist offered to contact the GP to suggest an alternative. The RP indicated that the pharmacy had a very good working relationship with the GP practice, so they were usually able to obtain replacement prescriptions very quickly. The pharmacy had a separate direct phone line to the medical centre so that he could easily speak to one of the GPs if necessary.

Prescriptions for CDs or fridge lines in retrieval awaiting collection were highlighted with laminated prompt cards and some put in a separate envelope so that staff would know that there were items to be collected from the fridge or CD cupboard. The pharmacist demonstrated the process to ensure that controlled drug prescriptions weren't handed out after their 28-day expiry. There were prompt stickers on the bags which included the date after which the prescription could not be handed out. The dates on Schedules 2, 3 and 4 CD prescriptions were highlighted with their expiry date. The prescription retrieval shelves were cleared every week of anything over five weeks old. One of the dispensary team would send a reminder text to the patient if possible before the medication was returned to stock and the EPS prescription returned to the NHS spine.

The pharmacy had recently completed an audit of valproate patients and had identified some in the at-risk group. Staff were aware of the risks involved in dispensing valproates to women in the at-risk group, and all such patients were counselled and provided with leaflets and cards highlighting the importance of having effective contraception. But the pharmacy was not currently confirming this at each subsequent supply. Upon reflection the RP agreed to brief his team and remind patients with each supply, and then record the intervention on the PMR.

Patients on warfarin were asked if they knew their current dosage, and their INR results were recorded on the PMR system. Patients taking methotrexate and lithium were also asked about blood tests. These interventions had been recorded as part of a recent PQS high-risk medicines audit, but not always on the PMR system. This was discussed and upon reflection the RP agreed that the PQS audit was a good starting point from which to continue recording these interventions on their PMR system. There were laminated prompt cards to go with the PIF to ensure that staff checked, and the key points were listed on the reverse to remind them.

The pharmacy supplied some medicines in multicompartiment compliance aids to a number of people. The RP outlined the process for ensuring that the prescriptions were ordered from the surgeries on time. They worked to a four-week cycle, and kept records of each persons' medication, when they were taken, any known allergies, any discharge information from the hospitals and contact details. If anything changed, a new record sheet would be produced to reflect the new situation rather than simply changing the existing sheet. He explained how they used this information to ensure that all of the necessary prescriptions had been received. The data entry (labelling) part of the process was only completed after they had received all of the required prescriptions, and the pharmacist had completed a clinical check to ensure that everything was as it should be. The compliance aids were then assembled in sufficient time for them to be ready for collection or delivery when needed. They included product descriptions and patient information leaflets (PILs).

The pharmacy provided an online anti-malarial service which the RP explained, as he was unable to demonstrate it without starting a live consultation. He described how he would conduct a consultation in the consultation room, taking the patient through a number of predetermined questions. These included capturing the details of any medication the patient was taking, or any allergies they may have.



The online form was then submitted to a pharmacist independent prescriber based at 'The Independent Medical Agency – Boots' who would then issue a prescription for the most appropriate medicine for the prophylaxis of malaria in the country or countries involved. The RP would then dispense the prescription and supply that anti-malarial medicine. The patient would also be supplied with a summary of the consultation and further patient information such as the need to take effective precautions against being bitten by mosquitos. The RP described a consultation where the prescriber did not automatically issue a prescription as a result of some declared allergies. The patient was then contacted directly by the prescriber to seek further clarification before issuing a prescription for a more suitable medicine. The private prescriptions issued through this service were appropriately recorded using the private prescription facility on the PMR system.

Medicines were obtained from licensed wholesalers including Phoenix, AAH, Alliance. Unlicensed 'specials' were obtained from Alliance Specials. The pharmacy was using the Columbus PMR system but was not yet using it to decommission stock in accordance with the requirements of the EU Falsified Medicines Directive (FMD).

Routine date checks were seen to be in place, and record sheets were seen for each quarter. Items approaching their expiry date were recorded on monthly sheets, and any left in stock one month prior to expiry were then disposed of. There were records present for items due to expire each month up to and including September 2020. There were a significant number of products on the shelves with 'caution: short dated' stickers on them. The RP explained that this was due to the way in which the Columbus system automatically ordered stock specifically for each prescription that had been entered the previous day. This led to existing stock remaining on the shelf for longer than it might have been when using their old system. The ACT explained how she also checked the expiry dates of every item as they arrived from their suppliers.

Fridge temperatures were recorded daily, and all seen to be within the 2 to 8 degree Celsius range. The ACT explained how she would note any variation from this and recheck the temperature every half an hour until it was back within the normal range. Pharmacy-only medicines were displayed behind the reception counter to prevent self-selection of these medicines.

Patient-returned medicines were screened to ensure that any CDs were appropriately recorded, and that there were no sharps present. Patients returning sharps were signposted to the local council for disposal. There was a tray containing protective gloves to help staff safely sort through any returned medicines. The pharmacy had a separate purple-lidded hazardous waste container for the disposal of medicines classified as hazardous waste. But there was no list of those medicines available for staff to refer to. The RP agreed to obtain one.

The pharmacy received drug alerts and recalls from the MHRA via 'my calendar' on 'Boots Live', printed copies of which were kept in a file. Each alert was annotated with any actions taken, the date and initials of those involved. The team knew what to do if they received damaged or faulty stock and they explained how they would return them to the wholesalers.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has adequate facilities for the services it provides, and it makes sure that they are properly maintained. It also ensures that people's private information is kept safe and secure.

### Inspector's evidence

The pharmacy equipment and facilities were seen to be appropriate for the services provided. The consultation room was clean and tidy. There was a range of crown stamped measuring equipment, counting triangles (including a separate one for cytotoxics, although it wasn't clearly labelled as such). There was one medicines fridge, and one CD cabinet. The pharmacy had up-to-date copies of the BNF and BNF for children, as well as internet access which they used as an additional reference source.

Access to PMRs was controlled through individual passwords, which had been changed from the original default password. Computer screens were positioned so they were not visible to the public. Staff were seen to take precautions such as moving to the rear of the dispensary when making telephone calls so as not to be overheard. NHS smartcards were seen in use with no sharing of passwords.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✓</span> <b>Excellent practice</b>	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.
<span style="color: green;">✓</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✓</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.