General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 120-122 Tottenham Court Road, LONDON, W1T 5AP

Pharmacy reference: 1041340

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

The pharmacy is located on a busy high street near University College Hospital in a mainly commercial area with people working locally in central London. 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 supply of a range of travel medicines and vaccinations including flu. 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 team identifies and manages the risks associated with providing pharmacy services by a variety of mechanisms including clearly written procedures for all services which they understand and follow.
		1.2	Good practice	The pharmacy team continually monitors its mistakes and can give examples of actions taken to stop the same sort of mistakes happening again.
2. Staff	Standards met	2.2	Good practice	The pharmacy team are encouraged and actively supported to undertake ongoing learning and keep their knowledge up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy makes it easy for people to access a variety of services. For example by opening early and providing hearing loops and large print information.
		4.2	Good practice	The pharmacy team manages and delivers services safely and effectively. It takes extra care with high risk medicines including valproate and methotrexate and makes sure people take their medicines in the right way.
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. The pharmacy team members identify and manage risk well. The pharmacy keeps the records it needs to show medicines are supplied safely and legally. It has written procedures which tell staff how to complete tasks effectively. 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 the welfare of vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed weekly but the pharmacist said the majority of selection near misses had decreased since the introduction of the new Columbus computer system. 'Lookalike, soundalike' (LASA) medicines laminates were displayed and 'select and speak it' alert labels were placed on the dispensary shelves near LASA medicines to reduce picking errors. Information was collated by staff in the patient safety review (PSR) and a trend in quantity errors during the dispensing process was identified rather than LASA errors. The PSR included information on current recalls and alerts. Action points included discussing how to reduce quantity errors with the pharmacy team, care when dispensing children's prescriptions and focus on hand out of prescriptions. An additional check of prescriptions awaiting collection had been introduced and there had been no incidents involving hand out of prescriptions reported. The latest Professional Standard (January issue) had been read and signed by staff and included a case study regarding asthma and analgesia (painkillers). In line with the Pharmacy Quality Scheme (PQS), supply of two LASA medicines had been risk assessed. When dispensing prescriptions, amitriptyline and amlodipine were highlighted on the pharmacist information form (PIF) and stock was separated on the dispensary shelves.

Workflow: using Columbus computer system, the prescription was scanned to generate labels and prescription image. If an incorrect item was picked and scanned, a warning message appeared on the screen. Stock was ordered automatically by Columbus during the dispensing process. 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. Interactions between medicines for the same patient were checked by the pharmacist during the clinical check. The four-way stamp on prescriptions was initialled identifying staff who dispensed, checked and handed out the medication. Special messages were recorded on the PIF including high-risk and LASA medicines, controlled drugs (CDs), owing medicines and interactions. The expiry date of 28-day validity of controlled drug (CD) prescriptions was recorded on the PIF. 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. Patients were texted to inform them there was a prescription ready for collection. If there was no mobile number, a note was added to the PIF to ask the patient for their mobile number. 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 available work space in the dispensary. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. A risk assessment for suitability of the service for a patient was completed. The pharmacy managed prescription re-ordering for patients. When prescriptions were received from the surgery they were checked for changes in medication. Any messages were noted on the PIF and patient medication record (PMR).

A folder retained information regarding compliance aids and each patient had their own polythene sleeve containing their discharge summaries and Medisure patient record. There was a discussion about ensuring the Medisure record was re-printed and not overwritten to clarify changes in medication. 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 sodium valproate, alendronate and CDs 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 separate to other medicines to ensure it was taken before other medication or food. Special instructions were highlighted on the backing sheet.

The annual patient questionnaire was conducted to obtain feedback about the pharmacy from members of the public. Cards were distributed to members of the public asking them to complete a survey at 'talktobootspharmacy.com'. Staff were informed when members of the public had reported positive feedback regarding service offered by staff. The patient guide with information relating to the pharmacy was displayed.

Members of the pharmacy team were up-to-date with training in standard operating procedures (SOPs) at the time of the visit. The most recent training in SOPs included core dispensing and CD procedures. Updated steps included an extra check and care on transfer of CDs to the patient and an enhanced audit trail when receiving CDs from the wholesalers. The 'handing out' prescriptions and sales protocol procedures were displayed for staff reference. The pharmacy advisor who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. The pharmacy advisor explained the sales protocol questions she would ask when selling combined ibuprofen and codeine products to the public. The pharmacy advisor said she would refer a diabetic patient to the pharmacist regarding treatment for corns.

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 prescription supplies were complete. Valid patient group directions (PGDs) were seen for a new service not yet operational, test and treat cystitis and travel vaccinations including yellow fever. Malaria prophylaxis was available via the Boots online service.

The CD registers were generally 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 tablets reconciled with the recorded balance in the CD registers. Footnotes correcting entries were mostly signed and dated. Invoice number and name but not always address of 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 Boots fair data processing notice and NHS your data matters notice was displayed. 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. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends

training. The pharmacists had undertaken level 2 safeguarding via Centre for Pharmacy Postgraduate Education (CPPE). The Professional Standard (PS) included a reminder to complete safeguarding training. Staff could refer to a dementia friends checklist and there were dementia friends posters and leaflets raising awareness of the condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team works effectively together and manages the workload in the pharmacy. They work in a supportive environment and are actively encouraged to undertake ongoing learning. Team members make suggestions to improve the pharmacy's services.

Inspector's evidence

Staff comprised: two full-time pharmacists, two part-time pharmacists to cover weekends, three full-time dispensers (two accredited and one trainee) and six full-time medicines counter assistants. At the time of the visit, there was a vacancy for one full-time pharmacist which was covered by relief pharmacists.

At the beginning of the visit, the relief pharmacist was mostly working alone in the dispensary and there was a staff member to assist with taking in prescriptions and locating prescriptions awaiting collection. Although there were several people waiting at any one time, staff managed the queue and issued approximate waiting or calling back times for prescriptions. A member of the pharmacy team said a dispenser was on annual leave. Other staff were available to sell over-the-counter medicines.

Staff were allocated protected learning time to complete training and had their own online training profile where they could access ongoing training appropriate to their role via eLearning and tutor packs. On completion of a study topic there was a knowledge test. Study topics included Health and Safety (stairs, manual handling), over-the-counter medicines, and information governance. Staff were also required to read the PS and updated SOPs. The pharmacist said she regularly observed staff selling over-the-counter medicines following sales and CARE protocols. Training certificates were filed for Pharmacy Quality Scheme (PQS) training which included safeguarding, sepsis, reducing LASA errors and risk management.

Staff performance was monitored via annual appraisal and regular reviews. Positive feedback from members of the public was related to staff via 'Star of the month'. Pharmacists attended 'Let's Connect' twice a year to meet with peers, be updated on company news and complete some continuing professional development in a topic such as mental health. There were regular team meetings to discuss near miss review and if tasks were completed up to date. Staff felt able to provide feedback and described rearranging the dispensary stock to maximise space and workflow. There was a whistleblowing policy. Staff said targets and incentives were not set in a way that affected patient safety and wellbeing. The pharmacist said she arranged travel vaccination appointments to manage the dispensing service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a clean, safe and secure environment for people to receive healthcare services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

Inspector's evidence

The pharmacy was located on a corner site. The dispensary and medicines counter were to the left and back of the pharmacy. The dispensary was small, narrow and well organised. Benches were clean and clear. The consultation room was locked when not in use and protected patient privacy. It was clean and tidy and there were three chairs for the pharmacist and members of the public accessing services. Posters of the procedures to deal with needlestick injury and administration in the event of anaphylaxis were displayed. Lavatory facilities were not seen during the visit. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy opens early and stays open later than usual. People with a variety of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. It makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy team members take the right action if any medicines or devices need to be returned to the suppliers. 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 and a hearing loop to assist hearing impaired people. Large font PILs could be printed to assist visually impaired patients. Staff could converse in Turkish, Kurdish, German, Dutch and Spanish to assist patients whose first language was not English. Patients were signposted to other local services such as nearby pharmacies to measure blood pressure and a sexual health clinic for emergency hormonal contraception. 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 to be explained on the pregnancy prevention programme (PPP). There was printed information to give to people regarding valproate and PPP. The intervention was seen to be 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 were posters regarding supply of sodium valproate and isotretinoin displayed in the dispensary. The prescriber was contacted regarding intervention for prescriptions for more than 30 days' supply of a CD.

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 PIFs and a laminated card specific to the medicine was included with the prescription. The laminated card was colour coded and included relevant questions to be asked by the staff member handing out the prescription. 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 were 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. People were advised to seek medical advice if they developed an unexplained fever. People taking lithium were asked when they had had blood tests to test thyroid and liver function and a record was entered onto the PMR.

The pharmacist was healthy living leader and two dispensers were healthy living champions. There were posters and information displayed in the health zone to raise public awareness of 'Call 111', Alzheimer's Society, Dry January, reducing antibiotic resistance and seeing the pharmacist about minor illnesses. An audit had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drug (NSAID). Other audits included: use of inhalers in asthma treatment in children and adults, identifying people in the at-risk group taking sodium valproate, monitoring patients taking lithium and diabetic patients regarding foot checks and retinopathy screening.

Medicines and medical devices were obtained from Alliance, AAH and Phoenix. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded on an ongoing basis and short-dated stock was marked with a sticker. 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 two medical fridges. One fridge was used for stock and one for vaccines. 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 printed, actioned, annotated and filed. Staff were reminded to action alerts and recalls via Boots intranet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. It uses these to keep people's information safe and protect privacy.

Inspector's evidence

Current reference sources included Medicines Complete and EMC. The dispensary sink was generally clean and there were clean stamped measures to measure liquids. The medical fridges were in good working order. 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. There was a CD destruction kit to denature CDs. The carbon monoxide meter for stop smoking was supplied and maintained by NHS Camden. The sharps bin for vaccination sharps disposal was kept under the desk in the locked consultation room. Adrenaline injection devices and ampoules for use to treat anaphylaxis were in date. 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. 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.