

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 211-212 Tottenham Court Road, LONDON,  
W1T 7PP

**Pharmacy reference:** 1077833

**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 treatment for hair retention, cystitis, substance misuse, needle exchange, pneumococcal and flu vaccinations. The pharmacy has healthy living status.

## 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
<b>1. Governance</b>	Standards met	1.1	Good practice	The pharmacy provides its staff with clearly written procedures and it make sure they work safely and effectively by following these procedures.
		1.2	Good practice	The pharmacy team record their mistakes so they can take action to prevent the same sort of mistakes happening again and improve patient safety.
<b>2. Staff</b>	Standards met	2.2	Good practice	The pharmacy team are actively supported and encouraged to complete training and keep their knowledge up to date.
		2.5	Good practice	The pharmacy team members are comfortable about providing feedback to improve services.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	4.1	Good practice	The pharmacy makes it easy for people to access its services. For example by opening early and closing later and providing hearing loops.
		4.2	Good practice	The pharmacy team are good at taking extra care with high risk medicines and make sure that people take them safely.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are safe and effective. It identifies and manages 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 members make 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 to complete 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 to improve patient safety included: ensuring all near misses were recorded and support was given to staff to reduce near miss events, support for staff preparing multi-compartment compliance aids to reduce near misses, share learnings with staff at daily huddle and plan management of lunch hour busy period more effectively. The latest Professional Standard (January issue) had been read and signed by staff and included a case study regarding asthma and analgesia (painkillers). The model day poster was displayed to assist planning tasks and time management within the pharmacy.

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. The four-way stamp on prescriptions was initialled identifying staff who dispensed, checked and handed out the medication. Interactions between medicines for the same patient were checked by the pharmacist during the clinical check. 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. 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. The Columbus computer system could check stock held by nearby branches of the pharmacy. 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 Medisure preparation procedure was

displayed for staff reference. 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). There was a communications diary to record any messages relating to the pharmacy including queries about compliance aids.

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 and alendronate 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. The pharmacy liaised with the doctor regarding supply of levothyroxine and lansoprazole and whether to supply separately or in the compliance aid 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 services offered by staff. The patient guide was displayed and included information about the pharmacy services and how to complain. Members of the pharmacy team were up-to-date with training in standard operating procedures (SOPs) at the time of the visit. The pharmacist said there had been an audit recently of training records. Staff understanding of SOPs was checked. 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 recording of initial and final supply of CD owing medication in the CD register. 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. The pharmacy advisor explained that he would not sell Nurofen Plus and Solpadeine Max to the same person because they both contained codeine. He also said he would recommend treatment did not exceed three days when selling Nurofen.

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 and 'specials' supplies were complete. A valid patient group directions (PGD) was seen for test and treat cystitis.

The CD registers were generally complete and the balance of CDs and methadone was audited weekly in line with the SOP. The methadone register was generally complete although some headers were not always entered. A random check of the actual stock of MST 5mg tablets reconciled with the recorded balance in the CD register. Footnotes correcting entries were 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. FP10MDA prescriptions were endorsed at the time of supply.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). Information governance training had been completed as eLearning. 'Your data matters to the NHS' leaflets were 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.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team members work effectively together and manage 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 safety and workflow.

### Inspector's evidence

Staff comprised: two full-time pharmacists, two part-time pharmacists to cover weekend and days off), one full-time dispenser, one part-time dispenser, one full-time and two part-time medicines counter assistants. There was a vacancy for a part-time dispenser at the time of the visit.

Staff were allocated protected learning time to complete training. All pharmacy staff could access training via two portals. Staff had their own online training profiles where they could log in and access mandatory training such as Health and Safety (stairs, manual handling) and Information Governance or choose their own study topics appropriate to their role. There were regular knowledge checks on over-the-counter (OTC) medicines. Staff were also required to read the PS and updated SOPs. Training for Pharmacy Quality Scheme (PQS) included NHS Community Pharmacist Consultation Service (CPCS), 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' issued by head office. Pharmacists attended 'Let's Connect' events to meet with peers, be updated on company news and complete some continuing professional development. There were regular team meetings when the patient safety champion shared learnings such as near miss review and the MPSR. Staff felt able to provide feedback and had suggested improving task and time management by claiming green prescriptions with a bar code at the end of the day, dispensing prescriptions with large numbers of items at a separate work station so prescriptions with less items could be dispensed for waiting patients more quickly and marking OTC dispensary medicines such as creams with a retail price to improve workflow. 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, safe and suitable for the provision of healthcare 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 clean and tidy. The dispensary was located along the back-right wall of the pharmacy. There were two chairs in the public area for people who were waiting for prescriptions. The consultation room was located at the far side of the dispensary and was not locked when not in use. There were lockable cupboards to secure equipment and documents. There were two seats for the pharmacist and the person accessing the service. Patient privacy was protected. Health related leaflets were displayed and posters about dealing with anaphylaxis and needlestick injury. Lavatory facilities were not seen during the visit. There was sufficient lighting and air conditioning.

## Principle 4 - Services ✓ Standards met

### Summary findings

People with a variety of needs can access the pharmacy's services. The pharmacy opens early and stays open later than usual. It gets its medicines from reputable suppliers to protect people from harm. The pharmacy team members make sure that medicines are stored securely at the correct temperature so that medicines supplied are fit for purpose. They take the right action if any medicines or devices need to be returned to the suppliers. The pharmacy team makes sure that people have all the information they need so that they can use their medicines in the right way. They 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 Bengali, Gujarati, Spanish, Danish, Filipino, Arabic and Malay to assist patients whose first language was not English. Staff wore name badges with the flag of the country of the language they spoke. Patients were signposted to other local services such as a nearby branch of the pharmacy for travel clinic vaccinations, opticians and a sexual health clinic for emergency hormonal contraception.

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 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. The prescriber was contacted 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 PIFs and a laminated card specific to the medicine was included with the prescription. The laminated card was colour coded such as pale blue for lithium and brown for warfarin. Relevant questions to be asked by the staff member handing out the prescription were recorded on the reverse of the card such as dates of blood tests. CD prescriptions were highlighted with the 28-day expiry date recorded on the PIF and a coloured laminated card. Prescriptions for CDs requiring secure storage were supplied in a clear plastic bag to allow an extra check of the CD and with a red sticker endorsed with a 28-day expiry date.

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. The pharmacist checked the person understood the dose and 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 a blood test and a record was entered onto the PMR. The



pharmacist checked the person was carrying a lithium card and understood signs of toxicity.

There were posters and information displayed in the health zone to raise public awareness of 'Call 111' and claiming free prescriptions. Health campaign information was at the till where most members of the public would see it. There were dry January diaries and leaflets and information on 'Wellness Reboot' and Diabetes UK. 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 to treat asthma 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 including methadone 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 operational at the time of the visit. Drug alerts and recalls were printed and shared with the pharmacy team, 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 appropriately to keep people's information safe and protect privacy.

### Inspector's evidence

Reference sources were generally online and included Medicines Complete. The dispensary sink was clean and there were clean stamped glass measures to measure liquids including marked measures to measure methadone. There was a new fridge following a malfunction in the previous fridge. The pharmacist was monitoring the temperature and resetting the thermometer to ensure the range was two to eight Celsius prior to moving cold chain stock into the new fridge. The CD cabinet was fixed with bolts. Adrenaline ampoules to deal with anaphylaxis were in date. The sharps bin for vaccination sharps disposal was kept in the dispensary between administration of vaccinations. The sharps bin for needle exchange was accessed through a hatch by the service user. There was a tray, safety goggles and strong gloves for use when dealing with patient returned medicines. 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.