

Registered pharmacy inspection report

Pharmacy Name: Boots, 322A Malden Road, North Cheam, SUTTON,
Surrey, SM3 8EP

Pharmacy reference: 1084653

Type of pharmacy: Community

Date of inspection: 24/02/2020

Pharmacy context

This is a small branch of Boots by a GP surgery and the leisure centre in North Cheam, Surrey. It is accredited as a Healthy Living Pharmacy (HLP). Its main activity is dispensing NHS prescriptions, mostly for people coming in from the adjacent surgery. 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
1. Governance	Good practice	1.1	Good practice	Members of the pharmacy team complete regular competency assessments such as quizzes to provide assurance that they understand their SOPs. There is a business continuity plan in place and staff know where to find it and what it is for.
		1.2	Good practice	Records of errors and near misses are regularly, and thoroughly, reviewed and detailed records are kept showing what has been learned and what has been done.
		1.3	Good practice	There are regular checks to provide assurance that staff are operating in accordance with their agreed roles and responsibilities.
		1.7	Good practice	All members of staff receive information governance training when their employment begins, and then get regular refresher training to provide assurance that they understand their responsibilities.
2. Staff	Good practice	2.1	Good practice	Staff do not appear pressurised and are able to complete tasks properly and effectively in advance of deadlines. Particularly in view of their total volume of work.
		2.2	Good practice	Planned learning and development is actively encouraged. Records show that staff complete regular ongoing training to keep their knowledge and skills up to date.
		2.4	Good practice	Members of the pharmacy team demonstrate enthusiasm for their roles and can explain the importance of what they do. There is evidence of effective team working to achieve common goals.
		2.5	Good practice	Regular team meetings are held and minutes are recorded and shared. This is particularly relevant as the team's shift patterns are spread out over long hours

Principle	Principle finding	Exception standard reference	Notable practice	Why
				and there is evidence of good communication between them all.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Information about medicines awaiting collection is effectively highlighted so that appropriate checks can be made and people suitably counselled. There are good records of those checks and of the counselling provided.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Good practice

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. It also has good processes to check that they are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy keeps detailed records of the mistakes it makes during the dispensing process. The patient safety champion regularly reviews them with each member of the team so that they can learn from them and avoid problems being repeated. Overall the pharmacy keeps very well-organised records. It 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. There were also signed training logs present in the folder for the new SOPs verifying that each member of staff had read and understood them. There were quizzes for each member of staff to complete on a selection of SOPs, with completed records present for each member of staff. The most recent quiz form present was for the high-risk medicines SOP dated November 2019. 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 clipboard by the main checking workstation. The registered technician, who was the 'patient safety champion,' reviewed them with each individual member of staff, and 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. Each individual member of staff also had their own 'Individual Performance Tracker' form where their individual near misses and errors had been recorded and reviewed. The technician explained how she used this and the 'Near Miss Incident Analysis Tool' to help identify individual trends and to help find ways of reducing the chance of the same mistakes happening again. There was also a matrix confirming that each member of staff had been briefed on the PSR each month. The most recent PSR recognised that there had recently been improvements in patient safety and that errors had decreased, mostly due to incorrect quantities being selected. Actions agreed for the following month included checking 'Repeat Dispensing' (RD) batches before reordering prescriptions for people, to avoid unnecessary duplication. The responsible pharmacist (RP) explained that they had introduced the new Columbus patient medication record (PMR) system a few months beforehand and had since seen a reduction in selection errors. They highlighted 'Look Alike Sound Alike' (LASA) drugs on the pharmacist information form (PIF) to help avoid picking errors. They had also put '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.

A business continuity plan was in place 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 83.5% of respondents rated the pharmacy as excellent or very good. There was a complaints procedure in place, and this was detailed in a patient guide leaflet in the leaflet display on the wall. 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 usually available at the prescription reception counter but had all been used up and more were on order. The RP explained that they always attached one of those cards to completed prescriptions that had been remotely assembled in the dispensing support pharmacy (DSP) in Preston. 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 some were seen to have the incorrect prescriber details recorded. This was discussed and the RP agreed to brief the rest of the team about the importance of recording the correct prescriber details in future. Emergency supply records were also maintained electronically, complete with details of the emergency and a detailed reason for supply.

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. There were a small number of patient-returned CDs awaiting destruction. Records of unlicensed 'specials' were complete with all the necessary details. 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 described how she had recently completing an online information governance (IG) training module, and 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 signposting folder, and also in the safeguarding section of the pharmacy duty log. 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 ✓ Good practice

Summary findings

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

Inspector's evidence

There were three pharmacy advisors, one registered technician one registered accuracy checking pharmacy tech and the responsible pharmacist (RP), on duty during the inspection. A second pharmacist arrived part way through the inspection to cover the end of the day. The RP explained that they usually have a second pharmacist with an overlap to cover lunchtimes. The size of the team appeared to be appropriate for the workload. In the event of staff shortages, they would adjust their working hours to cover each other. 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. There were 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 pharmacist confirmed that she was comfortable with making decisions and did not feel pressurised to compromise her professional judgement. She emphasised that she would only conduct a medicines use review (MUR) if she felt it to be clinically appropriate and of benefit to the patient. 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 manager conducted periodic reviews with her team to discuss performance and areas for development. Each member of staff had an up-to-date personal development plan in place.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are very small for the volume of its work. But they are sufficiently well laid out to provide a safe, secure and professional environment for people to receive its services. The premises include a private room which the team uses for some of its services, its administration and for private conversations.

Inspector's evidence

There was step-free access into the pharmacy through a single door from the pathway to the medical centre entrance. The premises were accessible to people with pushchairs or those with mobility issues. The pharmacy premises were very small, but were clean, tidy and in a reasonable state of repair. The dispensary was also very small but was very well organised with separate assembly and checking areas. There was a separate area just off the dispensary which was used for assembling multicompartiment compliance aids, and for checking off those prescriptions just returned from the DSP. They were kept reasonably tidy and free of clutter, in spite of the high throughput of prescriptions. There was just sufficient space to work safely and effectively and the layout was suitable for the activities undertaken.

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 a chaperone policy notice on the door for people to see. There were files containing confidential information on open shelving inside the consultation room, but a healthcare advisor explained that a member of staff was in there most of the time and that nobody else would be in there alone. The door was kept closed during the day and locked overnight.

The sink in the dispensary was clean, had 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. It identifies people supplied with high-risk medicines and keeps good records of the checks that it makes. And of the extra information it gives them to help them take their medicines safely. 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.

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 a PIF 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. 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. 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. Private prescriptions were manually endorsed with the 'quad stamp' for recording the same audit trail as recorded on NHS prescriptions.

Some of the pharmacy's prescriptions were dispensed offsite at the company's centralised DSP in Preston. The accredited checking pharmacy technician (ACPT) 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.

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.

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. The pharmacy had recently completed an audit of valproate patients and all interventions were recorded on the PMR system.

Patients on warfarin were asked if they knew their current dosage, and their INR results were recorded on the PMR system. The RP explained that the GP surgery didn't issue prescriptions unless the patient had a recent INR reading, and they frequently came into the pharmacy with their printout. Patients taking methotrexate and lithium were also asked about blood tests. All of these interventions were recorded on the PMR. 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 technician outlined the process for ensuring that the prescriptions were ordered from the surgeries on time. There were four 'Medisure' folders, one for each week of the four-week cycle. They contained records of each person's medication, when they were taken, any known allergies, any discharge information from the hospitals and contact details. She 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).

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 August 2020.

Fridge temperatures were recorded daily, and all seen to be within the 2 to 8 degree Celsius range. Staff explained how they would note any variation from this, completing the 'store checklist for investigation of fridge or freezer anomalies' form if necessary. A small selection of pharmacy medicines were displayed behind closed glass doors in a cupboard by the reception counter. There were signs on the doors to discourage self-selection of those 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 and goggles to help staff safely sort through any returned medicines. The pharmacy had no separate purple-lidded hazardous waste container for the disposal of medicines classified as hazardous waste. And there was no list of those medicines available for staff to refer to. The RP agreed to obtain them.

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 in the consultation room. 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 the right equipment for the range of services it provides, and it makes sure that it is properly maintained. The pharmacy takes reasonable steps to ensure 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). There were two medicines fridges, one for stock and the other for completed prescriptions awaiting collection or delivery. Reference sources were available, including the BNF and BNF for children. The pharmacy also had internet access and used this 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, and they were not left on the premises overnight.

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.