General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 7; The Brewery, Waterloo Road, ROMFORD, Essex, RM1 1AU

Pharmacy reference: 1085459

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

This is a community pharmacy located in a shopping centre in Romford and is open until midnight. As well as dispensing NHS prescriptions the pharmacy supplies medication in multi-compartment compliance packs for people who need help taking their medicines. It also provides flu vaccinations and supplies medicines for malaria prophylaxis as part of the Boots online medicines service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for training, training is monitored through regular conversations and any gaps in knowledge are identified.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. They proactively record and learn from any mistakes. This helps them make the pharmacy's services safer.

Inspector's evidence

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

In the event that a near miss was identified the pharmacist asked the team member to make an entry on the near miss log. The pharmacist also had a chat with the team member to see how the error could have occurred. The pharmacist explained that he had a discussion with the team member at the time that the near miss occurred and it was also discussed as part of the 'Patient Safety Review'. A review of all near misses and dispensing incidents was carried out once a month as part of the Patient Safety Review to identify any patterns. As a result of past reviews 'select with care' stickers had been attached on the shelves. Head office had identified a list of look-alike or sound-alike (LASA) medicines and lists of these were stuck on each workstation to prompt the team; warning labels were also stuck on the shelves near where these medicines were kept. The pre-registration trainee (pre-reg) discussed near misses with team members on the first Monday of each month when there was a cross-over in the team. After which she spoke to the store manager and created the patient safety report. Each month the team also read and signed the 'Professional Standards bulletin' which was sent by the superintendent (SI) and also covered learning from errors.

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. There had been three reported incidents in the past month at the pharmacy. As a result of this the area team had contacted the pharmacy as they had been concerned about the number of incidents. The pharmacist said that all three incidents had happened when different pharmacists had been working and had occurred as a result of self-checking. All pharmacists were briefed to take a mental break and were asked to ensure a second check was obtained where possible.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure in place and details of the customer care team were printed at the back of the receipts. Annual patient satisfaction surveys were also carried out. The team also handed out patient survey cards which could be completed online at any time with feedback sent to head office. The practice leaflet also had information on how people could raise matters further. In-store complaints were handled by the RP or store manager who would try and resolve them. If a complaint was made centrally this was cascaded to the store via the area manager and investigated. The pharmacist said that as a result of feedback more team members had been asked to work on Wednesdays and team members were asked to queue bust when they saw that a number of people were waiting. The pharmacy had also reviewed and made changes to the repeat prescription service including bringing forward the dates of when prescriptions were being ordered as they had noticed that people were coming in to collect their medicines earlier.

The correct responsible pharmacist (RP) notice was displayed. Team members were aware of the tasks

that could and could not be carried out in the absence of the RP.

Records for private prescriptions, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. Records for emergency supplies were generally well maintained but some of the entries did not have the reason for supply recorded. This could make it harder for the pharmacy to find out these details if there was a future query.

CD balance checks were carried out on a weekly basis. A random check of CD medicines complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored on a retrieval system and were not visible to people using the pharmacy. An information governance policy was in place and each year the team were required to complete training on the e-learning system. The team had also completed an e-learning module on the General Data Protection Regulation (GDPR). Team members had individual smartcards and passwords to access the NHS electronic systems. Pharmacists had access to Summary Care Records and consent was gained verbally.

The team had completed safeguarding training on the e-learning system; in addition to this all pharmacists had also completed the level 2 training. Details for the local safeguarding boards were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and team members work well together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver the pharmacy's services safely and effectively. They can make suggestions to improve the services that people receive.

Inspector's evidence

The pharmacy was open until midnight and the RP said that there was dispenser support for every working hour. At the time of the inspection the pharmacy team comprised of the store manager (a pharmacist), the RP, two trained dispensers and a trained medicines counter assistants (MCA). The pharmacy also had a pre-registration trainee.

The pharmacist (store manager) said that there were enough staff for the services provided. There was another two Boots stores nearby, one of which was larger and provided more services and had more dispensers. The pharmacist was able to request additional support from them when needed. The pharmacy was soon also due to start sending prescriptions to be dispensed at a central hub.

Staff performance was managed formally with reviews carried out. The store manager carried out quarterly reviews with team members and the initial performance development plan was set up at the start of the financial year. Team members were asked what achievement they were most proud of, what they could have done better and what their input was in the store meeting the targets on the scorecard. The store manager said that there was an opportunity for people to progress in their roles. And a dispenser was enrolled on the programme to qualify as a pharmacy technician.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was aware of the maximum quantities of some medicines that could be sold over the counter. She described handing out dispensed medicines in line with SOPs and said that she always showed prescriptions to a dispenser or pharmacist before handing the medicine out

The team were provided with regular training modules on e-learning which covered a range of different topics and areas. Training was monitored by the store manager. Team members were provided with half an hour training time to complete the modules. The latest training that team members had completed had covered the change in guidance for dispensing sodium valproate. The pharmacist said that this had also been covered in the SI's professional standards bulletin. New training was flagged to store managers. The MCA was also given books covering over-the-counter medicines to look through. One of the dispensers was undergoing training to become a pharmacy technician. The store manager said that the dispenser was given time to work through his course.

'Let's Connect' events were attended by the pharmacists and the store manager so that they could share learning with teams in other stores. The event covered key updates in pharmacy, company focuses and provided an opportunity to complete Continuing Professional Development. The RP said that the most recent event covered the multi-compartment compliance pack service (Medisure) and patient suitability. Teams were recommended to use an assessment tool to work out if people were suitable for the service.

The team held a discussion each Monday to discuss store performance and any focus areas. The store manager also checked how many people team members had signed up to certain services and based on this would decide who would work at the front counter and who needed additional coaching. Communication was also received from head office via email which the store manager cascaded to assistant managers. The latest information passed on had been in relation to age-restricted sales.

Team members including the RP felt able to give suggestions and feedback. The RP said that as the store manager was a pharmacist he understood any issues faced. The team said that the area manager also came in regularly and was open and receptive. There was also a confidential telephone line which team members could use to raise concerns.

Targets were in place for the services provided and the store had a target to deliver 400 Medicines Use Reviews (MURs) each year. The pharmacist said that target was not part of team member's contracts and did not make up part of the performance review. The pharmacists said that targets would not affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The pharmacy was spacious, clean and organised. There was plenty of workbench space available which was kept clutter free and was allocated for certain tasks. The pharmacy served people using the hatch from 8.00pm and had an intercom system fitted. Cleaning was done by the team. Medicines were arranged neatly on shelves on a carousel. A clean sink was available.

There were two consultation rooms available. Both rooms allowed for conversations to take place inside which could not be overheard on the outside. And were spacious, clean and tidy. Confidential information was stored securely inside one of the rooms, and the room was kept locked at all times. One room was predominantly used to hold conversations and the other was left for clinical services such as vaccinations. The premises were kept secure from unauthorised access. The temperature was regulated by an air conditioning system and was suitable for the storage of medicines. There was good lighting throughout the store.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are largely delivered in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts about medicines or medical devices to protect people's health and wellbeing.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. There was easy access to the pharmacy from the street with wide step-free entrance and power assisted doors. There was easy access to the medicines counter and there was a lowered counter for people using mobility aids. The pharmacy had the facilities to print large print labels. The pharmacy prepared multi-compartment compliance packs with large size fonts for one person. And it had a hearing loop. Team members were aware of the need to signpost people to other providers if a service was not available at the pharmacy and said that they would use the internet if they were not familiar with a particular service. Some team members were multilingual and the team also used online translation applications to help if people did not speak English.

The pharmacist said that he felt the New Medicine Service helped people as it was more proactive in allowing pharmacists to tell people why they were taking their medicines and counselling them if they experienced any side-effects, which he felt improved compliance. The pharmacist was the store manager and had a say in new services which were to be introduced in the pharmacy. He said that at the last area meeting he had discussed that his store should offer the Digital Minor Illness Referral Service as the pharmacy was open for longer hours and was also open at weekends. The pharmacy team were also looking to offer travel vaccinations.

The pharmacy had an established workflow in place. Prescriptions were received electronically and the team carried out a download of prescriptions a few times a day. These were then printed off and organised using an electronic system 'Webscript'. Prescriptions were dispensed by the dispensers and checked by the pharmacist. Pharmacist Information Forms (PIFs) were filled out at the point of labelling. This had information relating to allergies, interactions, eligibility for services or any other information the team member wished to relay. Warning laminates were also placed with high-risk drugs and those where pharmacist intervention was required. Laminates for high-risk medicines had question prompts at the back which reminded the team member on what to ask people when handing out their prescriptions.

The pharmacy had completed the audit for sodium valproate and the RP was aware of the change in guidance and the associated Pregnancy Prevention Programme. Prescriptions for anyone who fell in the at-risk group were highlighted. The pharmacy did not have anyone who fell in the at-risk group. The RP was not aware of the need to use the warning stickers when sodium valproate was not dispensed in its original packs. The inspector reminded him of the requirements.

When dispensing other high-risk medications, the RP and dispenser said that the warning cards were used. For warfarin prescriptions the RP checked the yellow book looking at the date of the last blood test and the targeted INR which was recorded on the patient medication record (PMR) for people who were regularly taking warfarin. For people who collected prescriptions for methotrexate the RP would

check and annotate the PMR if the book was seen. If the RP could not confirm the details the RP would speak to the GP.

A quad stamp was used which was initialled by all members of the team to create an audit trail for each stage of the dispensing and supply processes. Dispensed and checked by boxes on labels were also initialled by members of the team. The pharmacy team used tubs to ensure that people's prescriptions were separated.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Individual record sheets were in place for each person. Prescriptions were usually ordered a week in advance. Prescriptions were checked against the individual record and any missing items or changes were chased up and confirmed with the GP and a note was made on the individual record. Packs were prepared and sealed by the dispenser after which they were checked by the RP. If someone was admitted into hospital, the team were made aware by either the hospital or the person's representative. New record sheets were made when there was a change. Prepared packs were observed for a person which had been prepared in advance of the prescription being received. This was not in accordance with the company policies and could increase the chance of a mistake being made. The sealed packs had not been labelled and empty original packs were stored in the tray along with the assembled packs.

Assembled packs observed were labelled with mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly. Product descriptions were missing for some medicines. So, people and their carers may not always be able to identify which medicines are which.

Deliveries were carried out by drivers who were based at a hub. People were called prior to arranging delivery. The delivery driver used an electronic device to obtain signatures when medicines were delivered. In the event that the medication could not be delivered it was returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs and those requiring cold storage. Fridge temperatures were monitored and recorded daily, and these were observed to be within range. CDs were kept securely. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The RP was unsure of when the store was due to have this available to use.

Stock was date checked by the dispensers. Sections were checked on a weekly basis with the whole dispensary completed over 13 weeks. Stock going out of date was highlighted with a short-dated sticker, recorded and removed. There were no date-expired medicines found on the shelves checked. A date-checking matrix was in place. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

Drug recalls were received via alerts from Boots Live (the company intranet). The RP or regular pharmacists printed these out and they were signed and dated to show what action had been taken. If the regular pharmacists were not present the assistant manager printed the alerts and brought them to the pharmacy. The last alert for which some action had to be taken was for Clexane and Dovobet. The team were also briefed so that they checked stock as it was received from the wholesalers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. Separate measures were marked for methadone use only and a separate counter was used for cytotoxic medication to avoid contamination. Up-to-date reference sources were available including access to the internet. The pharmacy had three fridges of adequate size.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Confidential paperwork and dispensing labels were collected in blue confidential waste bags and then sent to head office for destruction.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.