General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2A Tottenham Hale Retail Park, Broad Lane, LONDON, N15 4QD

Pharmacy reference: 1093159

Type of pharmacy: Community

Date of inspection: 02/07/2019

Pharmacy context

This is a community pharmacy located in a retail park. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs. It also provides flu vaccinations. And offers a minor ailment and a needle exchange service.

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	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
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 generally identifies and manages the risks associated with its services. It largely keeps all the records it needs by law. And it asks people who use the pharmacy for their views. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe.

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. The pharmacy team had completed quizzes for some of the SOPs.

Near misses were recorded as they occurred. A Patient Safety Review was carried out at the end of the month to identify any trends. As the responsible pharmacist (RP) was a relief pharmacist she did not have a part in formulating the review but read through the completed review. The last action point from the Patient Safety Review was to ensure pharmacist information forms (PIFs) were used consistently. However, a number of assembled prescriptions were seen without PIF forms. The reviews had also identified that there had been an increase in the number of picking errors. As a result, if this the team had been asked to ensure shelves were kept tidy. Each month the team also read and signed the Professional Standards Bulletin which was sent by the superintendent and also covered learning from errors.

Team members said that when medicines which looked alike or sounded alike (LASA) were dispensed, dispensers read the product name aloud when picking stock. Head office had identified a list of LASA medicines and lists were stuck on each workstation to prompt the team. The team had also attached 'handle with care' labels near areas where they had identified that the team made errors.

Dispensing incidents were reported on an internal system which automatically submitted a form to the head office team. The RP said that she would also check if the person had taken any of the incorrect medication and as well as referring the person back to their GP she would also contact the GP. A dispensing incident had been reviewed as part of the Patient Safety Review conducted in May. However, neither the RP or dispensers could recall the details in relation to what had happened or any changes that had been made.

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. In-store complaints were handled by store manager who would try and resolve them. Previous feedback received had been in relation to waiting times, the team had agreed to acknowledge people as they arrived. However, this was not seen to be the case during the inspection.

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. The pharmacy had current professional indemnity insurance.

Records for emergency supply, RP records and controlled drug (CD) registers were well maintained.

Records for private prescriptions were generally well maintained but some of the entries observed did not have the correct date on which the prescription had been issued. This could make it harder for the pharmacy to find out these details if there was a future query. Records for the supply of unlicensed specials could not be located. The RP described that records that she would keep if she had dispensed an unlicensed special.

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 Boots Learning had training packs and e-Learning which covered confidentiality and Data protection training. The information governance training also needed to be renewed annually. The team had also completed an e-learning module on the General Data Protection Regulation (GDPR). The RP 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 the RP had also completed the level 2 training. Details for the local safeguarding boards were available in a folder in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy largely has enough trained team members to provide its services safely. But there are not always contingency arrangements to cope with staff absences. This means that the pharmacy may fall behind on its workload at times. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP (relief pharmacist), a trained dispenser and a pre-registration trainee (pre-reg). A second trained dispenser started her shift during the course of the inspection. The regular pharmacist was also the store manager, the pharmacy did not have any allocated counter assistants, although some members of the store team had completed their healthcare assistant course and were able to work on the counter. The dispensary team covered the medicines counter.
On the day of the inspection there were a number of prescriptions (over 15) waiting to be dispensed some which had been due on 18 June 2019. Team members said that they usually worked three days ahead but this had not been the case for the last few weeks as the pre-reg had been off for three weeks and both dispensers had been off consecutively during that time. There had been no cover provided during this time as team members said that the store had been assessed by the company as being a low priority. The RP said that she had walked into the pharmacy in this state in the morning and the store manager had come in to discuss with her what needed to be done. The RP said that the store was usually on track but due to a dispenser on holiday and pre-reg on study leave the previous week the store had been short staffed with only the RP and dispenser. However, as all team members had returned back from leave the team would be able to bring the workload back up to date.

The RP felt that there not always enough staff for the services provided. She said that the store had tried to get someone to cover the healthcare counter for a while but due to budgets set by the company this has not been possible.

There was an open working relationship in the team and team members felt that they were able to raise concerns to the pharmacists, store manager or higher management. The pharmacist mentioned that as the store manager was also a pharmacist he was able to understand the importance of some factors such as staff shortages on people's safety. She said that she was able to make suggestions which were taken on board.

The healthcare assistant (assistant manager) 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 prescriptions in line with the SOPs.

Staff performance was managed by the store manager who held annual appraisals with team members, these were then reviewed on a more frequent basis. The team were provided with regular training modules on e-learning which covered a range of different topics and areas. The latest training completed had been on Columbus. Team members were given set-aside time to complete their training.

The RP was signed up to a new programme to support newly qualified pharmacists in the first 1,000 days of qualification. This was part of a programme set up by the Royal Pharmaceutical Society (RPS). Boots ran study days as part of this foundation training. The RP had attended six to seven sessions in the last ten months. She said that each pharmacist was assigned a tutor who kept in touch with them during this period. The RP also went through training packs and went over the SOPs. The RP had a good working relationship with the Pharmacy Operations and Governance Manager (POGM) and would call them or the Boots professional guidance helpline if she had any queries related to things like CDs. The RP also a member of the Pharmacists Defence Association (PDA) and was able to call them as well as the RPS helpline if she needed additional help.

'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 RP had attended three events since starting in her role. She said that the events provided guidance; the last event had focussed on training the team and using different coaching styles.

No formal team meetings took place and things were discussed as they came up. The RP said that she felt able to give suggestions and feedback and share concerns. In the past she had provided feedback after completing a shift in which she had concerns. She had raised the concerns to the POGM and her line manager. Following this she had spoken to the deputy area manager and changes had been made.

Targets were in place for services offered and these changed each month. A pharmacy scorecard was updated each week. Team members said that there was a degree of pressure as the company had business needs. The RP did not feel any overwhelming pressure and said that she would always put people's safety first. She said that targets would not affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services and they are kept secure.

Inspector's evidence

The pharmacy was reasonably clean; there was ample workspace both at the front counter and in the dispensary area at the back. Workspaces at the back of the dispensary were mostly clear, organised and allocated for certain tasks. Although one side of the benches was cluttered with a number of trays and paperwork. Shelves were available at the back of the dispensary to place all prescriptions waiting to be checked or part-dispensed prescriptions. Multi-compartment compliance packs were prepared at the back of the dispensary. A counter at front was used for reception and to dispense walk-in prescriptions. A sign at the front counter was covered in pen marks and scribbles. Large assembled prescription bags were stored on the floor at the back of the dispensary. Cleaning was done by the team and a contracted cleaner also came in. Medicines were arranged neatly. A clean sink was available. The premises were kept secure from unauthorised access.

A signposted consultation room was available; the room was locked when not in use. The room was suitable for the services currently offered by the pharmacy. Information containing people's personal details was stored in a lockable filing cabinet. Although some records were found on the desk. Adrenaline pens were also kept in the room; these were taken into the dispensary by the RP during the inspection.

The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to regulate the temperature, this was controlled centrally.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And largely manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful, and they make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

Consideration had been given to ensuring that pharmacy services were accessible to all patients. There was step-free access into the store with power assisted doors and there was a hearing loop available. Aisles were also wide and clear with easy access to the pharmacy counter. The team were able to produce large-print labels and leaflets. The local population was diverse and multicultural with a high percentage of people from a Turkish or Somalian background. The store team was multilingual. The company had advised the team not to use any online translation applications. The RP said team members would call other stores where colleagues spoke different languages. Services were advertised using leaflets and posters and a sign in the shop window.

Team members were aware of the need to sign-post people to other providers if a service was not available at the pharmacy and said that they would use the internet or the signposting folder available to make referrals. Contact numbers were available for some of the other local healthcare providers who the team would call for the person to see if the service they were looking for was available.

The RP felt that the New Medicine Service (NMS) and Medicines Use Reviews (MUR) had an impact on the local population. She said that the duration of time people had with their GP during appointments was usually not long enough. And most appointments covered diagnosis. She said pharmacists could consult on side-effects and on administration. In the past the RP had identified side-effects which had resulted in referrals being made.

The bulk of the pharmacy's workload was from repeat prescriptions. The dispenser said when people collected their medicines, they were provided with the date of when their medication was due next and asked to tick what they needed. This request was filed according to the date of when the requests needed to be sent to the surgery. When the prescription was sent, the team generated a list of when prescriptions were due. This was crossed off when the prescription was received. Prescriptions were booked into the 'Webscript' system (the pharmacy electronic record system) and arranged in terms of the dates that they were due. Data from the prescription was entered onto the system which ordered the stock. The barcode on the pack was then scanned which generated a label. Team members said that a label was only generated if the correct item had been picked. Pharmacist Information Forms (PIFs) were filled out at the point of data entry. 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 what to ask people when handing out their prescriptions. Prescriptions were checked by the pharmacist once they had been dispensed. PIFS were not observed to be used for all prescriptions dispensed. This could mean that all relevant information was not passed on to the pharmacist.

The pre-reg would refer anyone who brought in a prescription for sodium valproate who fell in the at-

risk group to the RP. The RP said that in the event that the person who the prescription for was not present she would confirm with the GP if the person was on the Pregnancy Prevention Programme (PPP). She said that in the past she had spoken to a person and counselled them on the change in guidance. The RP would make a record on the persons electronic record of any checks carried out. The RP also printed out guidance information and handed this to the person. The RP was aware of the need to use the valproate stickers but was unsure if the pharmacy had any.

Laminates were used for some high-risk medicines and 'select with care signs' were placed on shelf edges near where some high-risk medicines were stored. For methotrexate, the RP said she would check the dose and use a separate tablet counting triangle. She would counsel the person the it was a weekly dose and check for signs of toxicity. The RP preferred to hand out prescriptions for high-risk medicines and Schedule 3 and 4 CDs. Warfarin was kept separately on the shelves. The RP would ask for and check the person's yellow book and check INR, she would also speak to the person and check for side-effects; information was recorded on the electronic patient medication record. The RP was an anticoagulant pharmacist at another store.

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.

A list of people who were supplied their medicines in multi-compartment compliance packs was split into weeks. 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 a note made on the individual record. Prescriptions were labelled and stock was collected. Packs were then prepared and sealed after which they were checked by the RP. In the event that someone was admitted to hospital the team would check with the surgery if there were any changes and chase up new prescriptions. On some occasions the hospital sent discharge summaries which were filed with the person's record.

Assembled packs observed were labelled with product descriptions, 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.

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 sampled. A date-checking matrix was in place. Due to staff absences the team were a week behind schedule.

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 and the store manager also received an email. The RP said that the RPS also sent members emails. Alerts were printed out and filed in the dispensary. The RP was unsure of the last alert which had been actioned as she only worked at the pharmacy every two

weeks. The latest alert seen in the folder was for an FMD issue.

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 a fridge 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.