

Registered pharmacy inspection report

Pharmacy Name: Boots, 4 Dundee Street, CARNOUSTIE, Angus, DD7 7PD

Pharmacy reference: 1041709

Type of pharmacy: Community

Date of inspection: 28/01/2020

Pharmacy context

This is a community pharmacy on a main road close to the town centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines. The pharmacy offers the smoking cessation service and seasonal flu vaccination.

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	1.2	Good practice	The pharmacy records reviews of errors and what has been done to reduce the chance of them happening again. And it reviews actions from previous months' reviews to ensure improvements are meaningful and sustained.
		1.4	Good practice	The pharmacy uses feedback to improve services. Such as all team members inviting people into the consultation room if they would like to speak to the pharmacist.
2. Staff	Standards met	2.2	Good practice	The pharmacy gives all team members training time at work each week. It keeps records of training. Team members use a variety of different material. And trainee team members spend time with the pharmacist to enhance and consolidate their learning.
		2.4	Good practice	The pharmacy has a mentoring culture with senior team members identifying and supporting the training needs of trainees. The team discusses and responds to incidents that have occurred elsewhere in the organisation.
		2.5	Good practice	Team members complete staff surveys. The team discusses the results and individuals positively address issues 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

Pharmacy team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they review these and make changes to avoid the same mistake happening again. They monitor improvements from previous months. The pharmacy asks people for feedback. And team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. New SOPs were available for team members to read e.g. witnessing destruction of schedule two controlled drugs. Team members used quizzes after reading SOPs to ensure they had understood them and some were observed e.g. instalments in Scottish branches, high risk medicines, and medicines support. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were all clear about tasks undertaken by different rules e.g. ACT, manager and trainees. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to separate people's medication. And it had a clear process in place to enable the accuracy checking technician (ACT) to accuracy check dispensed medicines. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. This included emergency phone numbers and an emergency cascade, to contact if there was no pharmacist on the premises and phone numbers of head office personnel, suppliers and other healthcare professionals. The pharmacy followed a 'model day' to ensure all tasks were completed. And this was available in several locations in the dispensary for reference. The pharmacy had information on a variety of topics on the dispensary wall for reference including recent advice about coronavirus which was very topical. The pharmacy had a bell at the medicines counter for team members to request assistance from colleagues.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The team had weekly meetings, and team members discussed any trends or patterns. They also used a white board to highlight important points such as concentrating on quantities, remembering to write high risk items on pharmacist information forms (PIFs), and there as 'drug of the month' information. The pharmacy had lists of high-risk items with 'look alike, or sound alike' (LASA) names at all labelling points in the dispensary. Team members were required to note these on PIFs to draw attention to them when dispensing and checking. Recently a team member had not followed this process and there had been a near-miss with two of these preparations. The whiteboard also noted improvements e.g. less incidents with 'forms' and strengths following discussions previously. Team members had placed shelf edge labels in front of several high-risk items involved in incidents.

The pharmacy had a complaints procedure and welcomed feedback. The manager printed feedback received electronically for discussion. A few months' ago, someone had commented about

confidentiality. The team had discussed this and now offered use of the consultation room to every person who asked to speak to the pharmacist. People sometimes asked to purchase products from ranges not sold in this branch. The manager arranged to have stock transferred from other branches to avoid people having to travel to another town or city. Team members described a lot of positive feedback received from people.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. The pharmacist had made bespoke templates to assist with controlled drug running balance audits. And he recorded instalment numbers particularly from multicompartment compliance packs in controlled drug registers to help.

Pharmacy team members were aware of the need for confidentiality. They had all undertaken mandatory annual training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services which are increasing. Team members have access to training material to ensure that they have the skills they need. And the pharmacy gives them time to do this training. Pharmacy team members make decisions and use the professional judgement to help people. Team members can share information and raise concerns to keep the pharmacy safe. They make suggestions to improve services. They discuss incidents. And they learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist, 1 full-time accuracy checking technician (ACT), one full-time dispenser/manager, one full-time trainee dispenser, three part-time dispensers (30, 20 and 20 hours weekly), one weekend only trainee dispenser, and delivery drivers from the PDC. Team members were able to manage the workload. The pharmacy's dispensing volume was increasing. It had adequate staff currently to manage this. The manager attributed this increase to the team providing a great service, fast prescription collection service turnaround, well managed stock resulting in few 'owings', and contacting the surgery for suitable alternatives to items unavailable.

The pharmacy provided 30 minutes learning time each week during the working day for all team members to undertake regular training and development. They used e-learning modules, read SOPs, and company documents including the 'professional standard', fire marshal training, Boots healthcare way, and the new 'pharmacy school'. Team members had undertaken the first part which was a questionnaire to identify areas for development. The ACT recorded training undertaken and due. The pharmacy provided trainees with additional time to complete their coursework. And the pharmacist supported and supervised them. This was observed.

Team members had annual development meetings with the manager to identify their learning needs. They had development plans in place. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. Examples were described of sharing information about locum pharmacists to ensure the pharmacy was always adequately and safely staffed. Team members completed annual staff surveys and discussed results. The pharmacist described being aware that he needed to communicate better with the manager. Because of their day off pattern sometimes they did not see each other for three days so communication was very important. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from. These were contained in the company document, the 'professional standard'. And it had accompanying documents related to patient safety and dispensing accuracy. All team members read these, and many were on the dispensary wall for reference. Recent topics had included risks such as relying on memory, children's medicines and distractions when dispensing. Team members signed these to acknowledge that they

had read and understood them. The pharmacy team discussed incidents and how to reduce risks. The team had regular weekly meetings. The manager shared information from a weekly conference call regarding performance, and other topics including patient safety, sales promotions and the importance of providing good customer service. The pharmacy had several whiteboards that were used to share information e.g. patient safety, and information regarding patients who received multicompartment compliance packs. The company had a whistleblowing policy that team members were aware of. The pharmacy had a copy of it on the dispensary wall. The company set targets for various parameters. The team members described offering services to people who they believed would benefit, managing stock carefully to ensure availability and providing good customer service to ensure that people always returned to the pharmacy. Team members had recently requested an additional controlled drugs cabinet to provide enough space to store all dispensed medicines. This had been agreed and recently installed.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, large dispensary and back shop areas including storage space and staff facilities. The team used space to its advantage, separating different activities into distinct areas. The premises were clean, hygienic and well maintained. Team members cleaned the whole premises each Saturday. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. All team members used the room to have quiet conversations with people. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Team members invited people in to this area as required. Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. And they provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination. It had information available in the retail area to direct people to local self-help and support groups. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. The pharmacy delivered on the same day each week to people receiving regular deliveries. And it phoned people receiving 'one-off' deliveries to ensure they would be in.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they used pharmacist information forms (PIFs) to share information with the pharmacist. Team members described sharing information such as inappropriate date of supply and new items. The ACT described instances when she would make a judgement regarding dates or doses. And when she would refer to the pharmacist for confirmation, even though he had already undertaken a clinical assessment. She described an example of a person often ordering medicines early, but not early enough to be identified by the GP practice system. She contacted the GP practice, and this was appropriately addressed. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including labelling and handing out. The pharmacy used labelled shelves to store dispensed medicines waiting to be checked. Pharmacists or the ACT could check prescriptions in order that they were expected to be completed. The pharmacy had a timetable on the wall in the retail area and behind the medicines counter informing people when their medicines would be ready after ordering prescriptions. It always met expectation and team members texted people to let them know when their medicines were ready. People who received medicines in multicompartiment compliance packs sometimes took additional prescriptions to the other pharmacy which was close to the GP practice. The two pharmacies worked closely and ensured that these people's records were flagged. A team member from the other pharmacy contacted this pharmacy in these instances to find out what other medicines people took. The pharmacist was able to undertake a clinical assessment before making the supply. Team members described examples of people being prescribed additional paracetamol containing medicines or other strengths of a medicine that they were already on.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. It stored part-dispensed prescriptions in baskets on labelled shelves. It did not have many owings as team members managed stock carefully. They always tried to get items in short supply

from other suppliers as soon as possible. They worked closely with the other pharmacy and the GP practice so that all relevant personnel were aware of shortages.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time, at least a week before the first pack was required. It kept a complete audit trail of progress for each patient. Team members updated a chart on the dispensary wall that listed people's names, date of birth, day and method of supply. They updated with their initials and date when they had ordered prescriptions, received prescriptions labelled, undertaking a clinical check, assembled and accuracy checked. The pharmacy kept thorough records including patient profiles, PIFs and a chronological list of changes. Some people received two packs each week due to the number of tablets. The pharmacy kept a PIF describing which tablets went in which pack to ensure consistency. When the pharmacy received information about changes or actions required relating to packs, a team member placed the information into a basket which another team member checked several times a day to ensure that all actions were undertaken in a timely manner. The pharmacy also kept a communications book which documented any interventions. Team members placed packs waiting to be checked on labelled shelves with prescriptions, patient records and tablet packaging. They placed trays containing controlled drugs into a CD cabinet and placed the records etcetera on these shelves to ensure that they were checked as expected. Team members included tablet descriptions on labels, date of supply and patient details on the spine of packs and they supplied patient information leaflets with the first pack of each prescription.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately and put notes on record. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. These included some duplication and inappropriate inhaler use. Team members registered people for the chronic medication service then discussed answers to assessment questions with the pharmacist. The pharmacy had a lot of information on the dispensary wall and shelf edge labels in front of medicines to help team members with accuracy. This included lists of 'lookalike' and 'soundalike' medicines (LASA), 'select and speak' labels, information about high-risk items such as opioid patches, short supply items such as ranitidine and information about sharps bins. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. It also followed private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under a pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacist undertook flu vaccination. He had completed the required training, and he kept sundries required for the service in the consultation room. The manager/dispenser undertook most of the smoking cessation consultations. The pharmacist reviewed information from consultations and prescribed appropriate products following a PGD. A pharmacist, ACT or the manager/dispenser supervised consumption of methadone and buprenorphine in the separate area or consultation room.

They demonstrated how they carried the medication very discreetly to prevent any other people seeing it.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. They monitored and tested each other to ensure the protocol was always used correctly.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and sundries for vaccination including emergency adrenaline. And items for infection control such as wipes, gloves and sharps boxes. Team members kept crown stamped measures by the sink in the dispensary and had separate marked ones for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and back-shop areas inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented personal information being seen by any other people. Team members used passwords to access computers and never left them unattended unless they were locked.

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.