General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 20-22 Castle Street, FORFAR, Angus, DD8 3AD

Pharmacy reference: 1041755

Type of pharmacy: Community

Date of inspection: 06/04/2022

Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. The pharmacy provides a range of services, including, smoking cessation and Pharmacy First. It provides medicines against Patient Group Directions for emergency hormonal contraception, impetigo, shingles, and urinary tract infections. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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	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 identifies and manages the risks associated with its services to help provide them safely. And team members protect vulnerable people well. The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information. And people can provide feedback about the pharmacy's services.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. And the pharmacy had carried out workplace risk assessments in relation to Covid-19. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where a person had been supplied with a different person's medicine. The error was realised when the other person came to collect their medicine and it was not available. Near misses and dispensing errors were recorded and reviewed each month for patterns. The outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped team members to prioritise tasks and manage the workload. Plastic tubs were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy adviser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She knew which tasks should not be carried out if the pharmacist was absent from the pharmacy and there was no second pharmacist to provide cover.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were completed correctly. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked regularly. Liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacy manager said that she would

ensure that this information was recorded in the future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The complaints procedure was available for team members to follow if needed and details about it were available the pharmacy's website. The pharmacy manager said that there had not been any recent complaints. She explained that she would initially try to deal with any complaints in the pharmacy, but she would refer to the pharmacy's head office where needed.

Team members had completed training about protecting vulnerable people. The pharmacy manager could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members could give examples of action they had taken in response to safeguarding concerns. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they receive some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise any concerns and make suggestions and they have regular meetings. This means that they can help improve the systems in the pharmacy. The team members make professional decisions to ensure people safely take their medicines.

Inspector's evidence

There were two pharmacists working at the start of the inspection. One of the pharmacists finished their shift shortly after. There were three pharmacy advisers (one was the pharmacy manager). Team members had completed an accredited course for their role and the rest were undertaking training. They wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacy manager about the reporting process in the event that a team member tested positive for the coronavirus.

Team members appeared confident when speaking with people. One of the pharmacy advisers was aware of the restrictions on sales of products containing pseudoephedrine. She explained occasions where she would refer to the pharmacist. And these included if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist felt able to take professional decisions. The pharmacist said that he had completed the necessary training for the services offered, as well as associated training. He was aware of the continuing professional development requirement for the professional revalidation process. He had undertaken recent training for the influenza vaccination service. He explained that he regularly read pharmacy-related articles online, and he passed on important information to other team members. The pharmacist said that team members were provided with some ongoing training from the pharmacy's head office. One of the pharmacy advisers explained that she was currently in the process of reading the SOPs online. The pharmacist said that team members had to pass a short test to show that they had understood the SOPs before signing them. Team members could access the online training at home.

The pharmacy manager said that she carried out appraisals and performance reviews for team members. And the area manager carried out hers. Team members felt comfortable about discussing any issues with the pharmacy manager or pharmacist. The pharmacy manager explained that there were informal meetings held twice a day to discuss any issues and allocate tasks. Team members also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacy received the 'professional matters' magazine from the pharmacy's head office. This included important information about the pharmacy's services. Team members signed to show that they had read and understood the information.

Targets were set for the Pharmacy First service. The pharmacy manager said that the pharmacy regularly met the targets. Team members said that they would not let targets affect their professional judgement. And that the pharmacy's services were carried out for the benefit of the people using the

pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. But there were some medicines that were accessible to people using the pharmacy at the start of the inspection. The inspector discussed this with the pharmacy manager. The pharmacy manager explained that the pharmacy was waiting for the barrier to be correctly installed and this would then restrict access. A temporary barrier was used to restrict access to this area. There was a gap in the counter between the medicines counter and the dispensary counter. The pharmacy manager said that people using the pharmacy would occasionally access this area to speak with staff or to select medicines from the shelves behind the counter. She said that she would raise the issue again with the area manager. And in the meantime, team members would ensure that people did not access this area. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were two chairs in the shop area. One was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. But the other was directly in front of the counter. There were clear screens at the counter, but people often spoke to team members through the gaps. There were markings on the floor and posters reminding people to keep a suitable distance from each other.

The consultation room was accessible to wheelchair users and was located to the rear of the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power-assisted door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacy could produce large-print labels if a person needed them.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin, when possible. But a record of blood test results was not always kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said CDs and fridge items were checked with people when handed out. The pharmacy manager said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets or warning cards available. Pharmacist information forms were printed when dispensing labels were produced. These had important information about a person's medication and were kept with the prescription through the dispensing and checking processes.

Some people received medicines from Medicine Care Review prescriptions. These were usually processed a few days before the person needed their medicines. The prescription bar code was scanned, and the person's repeat profile was updated with the next prescription due date. Prescription trackers were used which included the date the medicines were collected and the date the next issue was due. A treatment summary report was printed and sent to the person's GP to request a new prescription once all allocations had been collected. People were contacted if they had not collected their medicines.

Consultation forms were completed when a person used the Pharmacy First service. All team members were trained to add the consultation notes on the computer system. Universal claim forms were signed by the pharmacist before medicines were supplied. Any advice given to a person was recorded on their medication record. If someone regularly asked for the same medicine, the pharmacist would speak with them with a view to a referral to another healthcare professional.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was marked. There were no date-expired items found with dispensing stock. The pharmacy kept lists of short-dated

items so that these could easily be identified and removed from dispensing stock before they had expired.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy used 'owings tracker' slips and any correspondence with the person's GP, the patient or the supplier was recorded. Uncollected prescriptions were checked weekly. People were sent a text message reminder if they had not collected their items after five weeks. Items remaining uncollected after a further week were returned to dispensing stock where possible and the patient's medication record was updated.

People had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. A progress log was used to keep track on the stage that the prescriptions were at in the process. A communication book was also used to ensure that information and conversations were available for all team members. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The pharmacy adviser said that the pharmacy contacted people to ask if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacy manager explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were used to measure certain higher-risk liquids. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had personal protective equipment available, including masks, gloves, and hand sanitiser.

Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.