General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 99 New Road, AYR, Ayrshire, KA8 8DD

Pharmacy reference: 1041806

Type of pharmacy: Community

Date of inspection: 18/04/2023

Pharmacy context

The pharmacy is amongst a row of shops in a residential area in the town of Ayr. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It supplies some people with their medicines in multi-compartment compliance packs to help them take their medication. The pharmacy provides people with other services such as the NHS Pharmacy First Service and it supplies serial prescriptions as part of the NHS Medicines: Care and Review (MCR) 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	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 well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it completes the records it needs to by law. Team members suitably protect people's confidential information, and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond correctly when errors happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to help team members safely manage the delivery of pharmacy services. And to clearly define their roles and responsibilities. Most SOPs were available to team members electronically and they received new and updated SOPs via the company's online training portal. Each SOP was accompanied by an assessment to test the team member's understanding. A few SOPs were paper based and an index identified where the team could locate each SOP. Team members read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. They were aware of the responsible pharmacist (RP) regulations and knew what they could do in the absence of a RP.

The pharmacist manager was an independent prescriber (IP) and was planning to provide the NHS Pharmacy First Plus Service. And had completed a risk assessment as part of this process. The pharmacist had experience of providing the service and used this to train the team and promote the service to people. The outcome of the risk assessment had determined that a small range of medicines would be initially provided until the team became accustomed to the service.

The pharmacy had a process to record errors made during the dispensing process, known as near misses which were recorded on an electronic near miss record. Near miss errors were highlighted to the team member involved by the pharmacist, and it was the team member's responsibility to enter it onto the record. Completed near miss records were not available for viewing at the time of the inspection as the new manager did not have access for this pharmacy. However, a team member entered a near miss onto the system to demonstrate their understanding. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. These records were also unable to be viewed but team members discussed dispensing incidents and how they could prevent them from happening again. A monthly review of all errors was undertaken by the pharmacy technician who shared the outcome with the team. Discussions were held amongst team members on the actions they could take to prevent similar errors from happening. This included asking a colleague to double check the medicine selected from the shelf.

The pharmacy had a concerns and complaints procedure which was detailed in an information leaflet located in the retail area. Most concerns were managed by the team members but if they could not resolve the concern it was escalated to the manager or RP on duty. In response to several people raising concerns about queues and social distancing requirements the team had installed a dedicated prescription collection point. This meant there was a separate area for people collecting their prescription from people requiring other services.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers and it checked balances in the CD registers against the physical stock to identify issues such as missed entries. The pharmacy maintained a register of CDs returned by people for destruction, but this did not always detail the team member who had witnessed the destruction. An accurate RP record was maintained and the correct RP notice was clearly displayed in the retail area. Team members had completed training on the General Data Protection Regulations (GDPR), and they separated confidential waste for secure shredding offsite. They kept sensitive material in restricted areas and they displayed details on how the pharmacy protected people's confidential information.

Pharmacy team members understood their obligations to manage safeguarding concerns. Team members discussed their concerns with the pharmacist and a list of contact details for relevant local agencies was displayed on the wall for ease of access. The pharmacist was registered with the Protecting Vulnerable Groups (PVG) scheme and had completed additional safeguarding training via NHS Education for Scotland (NES). Team members were aware of the Ask for ANI (action needed immediately) initiative, which helped people experiencing domestic abuse. And they displayed posters in the retail area advising people that the pharmacy offered a safe space.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to help safely provide its services. Team members work well together and the pharmacy supports them with ongoing training to advance their skills and knowledge. Team members are good at supporting each other in their day-to-day work and they take opportunities to provide encouragement and assurance to each other.

Inspector's evidence

The full-time pharmacist who was also the manager had been in post for a few days. Regular relief pharmacists had provided cover since the previous pharmacist manager left in September 2022. Present on the day of inspection was a full-time trainee pharmacy technician, one part-time dispenser and one part-time trainee dispenser. Other team members included a part-time dispenser and a full-time pharmacy technician. An additional dispenser had been recruited and was starting the following month. Annual leave requests were managed so that only one team member was absent at a time. And team members rotated key tasks so they could effectively complete all tasks especially at times of planned and unplanned absence.

Trainees in the team had some protected training time at work and were supported by other team members. The trainee technician reported they felt very supported by the team and company when undertaking their training. The pharmacy provided access to additional training for all team members via the company's online system. And they had some protected time at work to complete the training. Team members read the publication sent from the Professional Standards team that provided information about new services and learning from dispensing errors. And they signed the bulletin to record that they had done so.

Team members usually met three times a year with the pharmacy manager to discuss their performance and learning needs. But due to a change in manager recent meetings had not taken place. The new pharmacist manager had spent time with each team member to get to know them and discuss any concerns they had. Team members had daily meetings where they discussed the delegation of pharmacy tasks. They also had regular weekly meetings where they shared error trends and had the opportunity for informal feedback. During the COVID-19 pandemic a "feel good Friday" box was initiated by team members for them to share positive feedback about their colleagues. And the details from the feedback was shared at a team meeting. Team members found this helped with their morale and they decided to continue with this approach because of the positive impact it had.

Team members were aware of how to raise concerns and could raise concerns with their manager and area manager if necessary. There was a whistleblowing policy in place and a poster provided details of how to raise a whistleblowing concern. Team members were aware of some targets for the services provided such as the NHS Pharmacy First service. But they only provided the service when it was beneficial for the patient.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and appropriate for the services provided. And the pharmacy has suitable facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was generally clean and tidy except for the staff facilities which were dimly lit and needed a refit. There was a clean, well-maintained sink in the dispensary used for medicines preparation and other facilities for hand washing. The pharmacy kept heating and lighting to an acceptable level in the dispensary and retail area. Team members could raise maintenance concerns and had recently reported a rotten wooden window frame and a fault to the door of the consultation room, which had been fixed.

The pharmacy workspace was well organised with designated areas for completion of pharmacy tasks and suitable storage for pharmacy prescriptions. Pharmacy only medicines were stored behind the prescription counter to prevent unauthorised access. The medicines counter was clearly seen from the dispensary so the pharmacist could intervene in a sale when necessary. There was a good-sized consultation room that was suitably equipped which team members used for private conversations with people and when providing services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible. Team members manage these services well and they supply medicines safely to people to help meet their healthcare needs. They identify people who are prescribed high risk medicines to ensure they receive appropriate information to help them take their medication correctly. Team members store medicines properly and they regularly check to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a stepped entrance through a manual door which could be operated by a press pad. For people who had difficulty accessing the pharmacy there was a doorbell to alert team members and a portable ramp was available for team members to use. There was an information leaflet that provided people with details of the services the pharmacy offered and the contact details of the pharmacy. The opening hours and services offered were also displayed in the window. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They asked appropriate questions when people requested to buy an over-the-counter medicine to ensure it was suitable for them. And they knew when to refer to the pharmacist.

The pharmacist manager was in the process of setting up the NHS Pharmacy First Plus Service to enable treatments for a wider range of conditions to be offered. And had spoken to other healthcare providers to raise awareness of the service. Team members kept detailed records of the supply of medicines against serial prescriptions as part of the NHS Medicines: Care and Review (MCR) service. So, they could suitably manage any queries that arose about the supply of medicines through this service. The pharmacy dispensed private prescriptions issued by the company's online Doctor service which included prescriptions for weight loss medications. There were procedures in place for this service and the pharmacist when completing the clinical check of the prescription would raise queries with the prescriber. For example, the pharmacist had intervened in the supply of a weight loss medication when the person's body mass index (BMI) was not within the specified range for prescribing. This intervention was documented on the company's incident management system and shared with the quality manager.

Several people had their medication supplied in multi-compartment compliance packs to help them take their medicines. This was managed by the pharmacy technician with support from other team members. Prescriptions were ordered several days before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which was regularly referred to during the dispensing and checking of the prescriptions. Descriptions of the medicines within the packs were not always recorded which meant that people may not always be able to identify the medicines within the pack. However, the manufacturer's packaging leaflets were supplied with the packs so people had access to information about their medicines. Completed packs were bagged as weekly supplies and kept in magazine box files labelled with the person's details. These were held on a dedicated set of shelves.

Around 50 people received their medicines daily as supervised and unsupervised doses. The doses were prepared in advance to reduce the workload pressure of dispensing at the time of supply. They were

stored securely in alphabetical order and date order to help ensure the correct person's dose was selected. A final check of the pre-prepared dose was completed at the time the person presented. And the person was asked to confirm their details and the dose they were expecting.

The pharmacy had separate areas for labelling, dispensing and checking of prescriptions. There was also a defined area for preparing the compliance packs. Team members used containers to keep people's medication with the correct prescription. They signed the dispensed by and checked by boxes on dispensing labels to record who was responsible for dispensing and checking the prescription. The pharmacy also used a stamp to capture who had downloaded the electronic prescription, who had completed the clinical and accuracy checks and who had handed out the medication. Information identified during the dispensing process, such as a new medicine or a dose change was captured and kept with the prescription. This meant the pharmacist was aware and it prompted the team to discuss the information with the person when handing over their medication. Team members used alert cards for higher-risk medicines to prompt the pharmacist to ask for information from the person such as their latest blood test results. So, they could assess whether the medicines were suitable to supply. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. And they reported that no-one prescribed valproate met the criteria. The team stored completed prescriptions neatly in a dedicated area. And scanned the prescriptions into a particular location using a barcode attached to the location. When the person came to collect their prescription, the team used the barcode scanning to identify where the prescription was held and to check the correct prescription had been picked.

The pharmacy obtained medication from several reputable sources and the team members followed the pharmacy's procedures to ensure medicines were safe to supply. The dispensary fridge was clean, tidy and well organised and records of temperatures were maintained. A sample of completed records showed the maximum and minimum temperatures recorded were within the required range. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. Team members regularly checked the expiry dates on medicines and kept a record of this. There was no evidence of medicines with a short expiry date being marked but a recent stocktake had removed all out of date and short dated stock. A random sample of medicines were found to be in date. Some medicines boxes held additional tablet strips which had no batch number or expiry date on them. This meant the team could not action any safety alert for the medicine. And they would not know if the medication was in date. The manager was informed and advised this would be raised with team members to ensure it did not happen again. CDs were stored in accordance with legal requirements in approved cabinets. Expired CDs and CDs returned by people for destruction were clearly marked and segregated in the cabinets. Appropriate denaturing kits were available for the destruction of CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Team members printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF) and the BNF for children. There was also access to internet and intranet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. The team used a handheld pump for measuring supervised doses of medicines which was cleaned and checked each day to ensure it measured accurate doses. The pump was sent to an external company each year for calibration and an additional pump was provided to the team during this time. Safety checks on the electrical equipment regularly took place.

The pharmacy's computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones to enable team members to have private conversations with people. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.