General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1 Fullarton Square, IRVINE, Ayrshire, KA12 8EJ

Pharmacy reference: 1041831

Type of pharmacy: Community

Date of inspection: 28/11/2019

Pharmacy context

This is a community pharmacy in a large shopping centre in Irvine, Ayrshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the Minor Ailment Service (eMAS) and flu vaccinations. The pharmacy provides a substance misuse service. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery 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 team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They are good at discussing how they can make improvements. And they make changes to minimise the risk of similar mistakes happening in the future.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members are encouraged and supported to complete training to help them keep their knowledge and skills refreshed and up to date. The pharmacy achieves this by providing its team members with protected training time and regular performance appraisals.
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 the services it provides to people. And it has a set of written procedures for the team members to follow to help them deliver the services safely and effectively. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They are good at discussing how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of up-to-date written standard operating procedures (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. The pharmacy defined the roles of the pharmacy team members in each procedure. The team members had read and signed each SOP that was relevant to their role. And they were required to complete a short quiz sheet when they had been issued with new or revised SOPs. The team had completed questions on the pharmacy's core dispensing SOPs. An example of the questions asked included the length of a time a prescription is legally valid for. The pharmacy had up-to-date guidance and signed documents for the flu vaccination service. And, it had a declaration of competence from the authorised pharmacists confirming their training was up to date.

The pharmacy had a paper near miss log that held records of near miss errors made by the pharmacy team when dispensing. The team members recorded the time and date the error was made and the type of error. They also recorded the action taken and the reason why they error may have happened. They consistently completed the log fully and records were seen for the previous twelve months. The team members openly discussed the errors that happened. And they did this as soon as possible. This was to make sure they did not forget the details of the error and to make the team aware of the learning points straight away. The pharmacy appointed a team member to be the pharmacy's patient safety champion. The role of the team member was to analyse the near miss records each month for any patterns and trends. And to discuss any findings with the team in a monthly patient safety briefing. The results of each briefing were displayed on a wall in the dispensary for future reference. The team agreed actions to complete following each analysis. And they assessed success of those actions at the next briefing. The team members explained that the most common cause of near miss errors was because of team members rushing to complete the dispensing of prescriptions while people waited. The team members explained that they did not want people to be waiting too long for their prescriptions and as a result, they often gave them unrealistic waiting times. To help them prevent further errors from happening, the team discussed what they could do to improve. They talked about giving people more realistic waiting times. The team explained this helped them work under less pressure and helped them better manage the expectations of people. The pharmacy had a process to record and report dispensing incidents that had reached the patient. It recorded the details of such incidents using an electronic reporting system called PIERS. A sample of some records were seen. Within the sample the team had recorded the full details of the error, who had been involved, why the error might have happened and what the pharmacy intended to do to prevent a similar error happening again. Recently the pharmacy had dispensed the incorrect number of medicines into a person's multi-compartment compliance packs. The team had all discussed the error at the earliest opportunity. The

team members decided to implement a system for them to count the number of medicines that should be in the packs. And write the number at the bottom of the prescription. The number was then used as a reference when the final accuracy check was completed. This change of process was seen to have been implemented during the inspection.

The pharmacy used small paper slips called pharmacist information forms (PIFs). They were used to communicate messages to the pharmacist such as if a person was eligible for a service, for example, a flu vaccination. Or if there were any changes in dose or directions. The team members also used the forms to inform the pharmacist if the medicines being dispensed were look-alike or sound-alike (LASA) medicines and were therefore at a higher risk of being involved in an error. The pharmacy had a list of the most common LASA medicines attached to each workstation. It also had 'select and speak' stickers attached to the shelves in front of several LASA medicines. The stickers were designed to encourage the team members to 'speak' the name of the medicine before they selected it. The stickers had the middle of the name of the medicine written in capital letters to help the team members make a clear distinction between the two medicines. For example, amLODipine and ami TRIPtyline.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist. The team members used a stamp split into four sections to record which team member had accuracy checked the prescription, clinically checked the prescription, dispensed the medicines and handed out the medicines. This ensured the pharmacy kept a robust audit trail of dispensing activities.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's practice leaflet which was available in the retail area for self-selection. The pharmacy collected feedback through online questionnaires and a link to the questionnaire was printed on the reverse of each till receipt. The team members explained that the comments they received were generally positive, but the most common area for improvement was the time people had to wait to be served at the pharmacy counter. To improve, the pharmacy had made some changes to the staff rotas to ensure a team member was free to acknowledge people as soon as they presented at the pharmacy counter.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of dexamphetamine 5mg tablets matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team was aware of the need to keep people's personal information confidential. And team members were seen offering the use of the consultation room to people or moving to a quieter area of the retail area, when discussing their health. They had all undertaken General Data Protection Regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

Each team member was PVG registered and when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary. The pharmacy encourages and supports its team members to complete training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with a protected training time and regular performance appraisals.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the regular pharmacist who had been working at the pharmacy for several years. A trainee pharmacy assistant, two qualified pharmacy assistants and the pharmacy's store manager supported her. The pharmacy also employed an accuracy checking technician (ACT), another trainee pharmacy assistant and another qualified pharmacy assistant. Many of the team were new to the pharmacy and so the pharmacist and the pharmacy's store manager had recently assessed the staff rotas and made several changes. For example, they ensured the pharmacist was always working alongside at least one qualified dispenser. The pharmacy was particularly busy on weekends, with people purchasing over-the-counter products. And so, the rotas had been changed to ensure more team members were working during the busier periods of weekends. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The pharmacy provided the team with additional pharmacist support if the ACT was absent. The pharmacist explained that several team members had recently stated that they felt the pharmacy did not have enough staff during the summer months, particularly when people took holidays. The pharmacist discussed the feedback with the pharmacy's store manager. The pharmacy was provided with relief staff cover when the team felt they were falling behind with their workload. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules. The modules covered various topics, including mandatory compliance training covering health and safety and information governance. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. The pharmacist explained recently the pharmacy had a focus on ensuring that the team members were following the correct procedure when handing out dispensed medicines to people, to prevent any hand out errors happening. For example, supplying medicines to an incorrect person. The pharmacist said she routinely observed the team members while they handed out dispensed medicines to people. And she did this without the team member's knowledge. The findings of the observations were recorded and discussed

with the team member. In a recent example, the pharmacist said she discussed with a team member the importance of ensuring the address of the person was checked against both the prescription and the bag label.

The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. They could also take the opportunity to give feedback to improve the services the pharmacy offered. The team members felt comfortable to raise professional concerns with the regular pharmacist or the store manager. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was tidy and well organised during the inspection and the team had ample bench space to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. It engages with people using the pharmacy to help them improve their health. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the shopping centre walkway. Which allowed people with prams and wheelchairs to enter the pharmacy unaided. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours in the main window and on the pharmacy's website. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services. The pharmacy had up-to-date patient group directions (PGDs) for the administration of flu vaccinations and for the pharmacy first service. The pharmacy first service allowed the pharmacist to provide prescription only medicines to people without a prescription. The medicines were for conditions such as impetigo and mild urinary tract infections. The service was popular with the pharmacy completing around 200 consultations a month. The pharmacist explained she went through a rigorous screening process with each person to make sure they were eligible for the service. Recently the pharmacist had referred a person to an emergency eye clinic following a pharmacy first consultation.

The team members regularly used various laminated cards during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. They used 'CD' laminated cards to keep with prescriptions. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in a separate room on the first floor of the

premises. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents related to each person on the service in separate wallets. The team members used progress charts which they attached to a wall. The charts helped the team visually assess the progress of the dispensing. The documents included master sheets which the team members used to check off prescriptions and confirm they were accurate. They used 'communication record' slips to record details of conversations they had with people's GPs. For example, if they were notified of a change in directions, or if a treatment was to be stopped. The packs were supplied with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used separate laminated cards.They kept these with people's prescriptions as a reminder to discuss the person's treatment when handing out the medicine. There were example questions on the reverse of the cards to remind the pharmacist to ask the person collecting various questions to make sure they were taking their medicines safely. For example, the pharmacist asked for the persons current and target INR, their daily dosage and the date of their next blood test. But records of these conversations were not retained. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. Two people had been identified and were given appropriate advice by the pharmacist.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next 12 months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.