General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 12-14 Lyon Square, GLENROTHES, Fife, KY7 5NR

Pharmacy reference: 1042085

Type of pharmacy: Community

Date of inspection: 22/09/2022

Pharmacy context

This is a community pharmacy within the main shopping centre of Glenrothes. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers 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.

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 mostly identifies and manages the risks with its services. It keeps people's private information secure. And the team is adequately equipped to manage any safeguarding concerns to help protect vulnerable people. Team members record and report details of mistakes they make while dispensing and they make some changes in practice to reduce the risk of further mistakes. Pharmacy team members mainly follow the pharmacy's written procedures to help them safely carry out tasks. And they keep the records they need to by law. But some record keeping is not robust, introducing risk into the system.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser at the premises entrance.

The pharmacy had a full range of standard operating procedures (SOPs). The team was currently in the process of moving these to an online platform, so these were kept in both a folder and online. There was evidence of team members having read and agreed to follow them. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy received occasional support from an Accuracy Checking Technician (ACT) who was usually based in another of the company's pharmacies. Team members were able to describe the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions.

Team members used electronic 'near miss logs' to record dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. They reviewed near misses and errors each month as part of a patient safety review. A team member explained that due to staffing problems, the pharmacy had not had time to complete the reviews regularly. And they couldn't give any example of recent changes made as a result of these reviews. A team member explained the team did not have many incidents since the dispensing system, using barcode technology, had been installed. The inspector noted warning stickers on the shelves next to medicines that looked or sounded like each other. The stickers helped remind team members that these medicines were at a higher risk of being dispensed in error. The pharmacy had a complaints procedure and welcomed feedback. People initially raised any complaints or concerns verbally with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's area manager.

The pharmacy had current indemnity insurance. The pharmacy displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records of emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept controlled drug (CD) records with running balances. The inspector noted that stock balances had previously been checked on a weekly basis as per the SOP. But the period between some checks had increased recently reportedly due to staffing pressures. The pharmacy did not have a robust process for managing CDs returned by people. The pharmacy backed up electronic patient medication records (PMR) to avoid

data being lost.

Pharmacy team members were aware of the need for confidentiality. They clearly separated confidential waste and this was taken away for secure destruction centrally. No person identifiable information was visible to the public. The pharmacy had a documented procedure to help the team raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. They were aware of the Ask for ANI (action needed immediately) system to help people suffering domestic abuse access a safe place. They knew how to raise a concern locally and had access to contact details and processes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members who work well together. And it supports its team members by enrolling them on a qualification course appropriate to their role. They ask appropriate questions and provide suitable advice to people. The high proportion of inexperienced team members means they do not always complete tasks as efficiently as possible, whilst they are learning. And some tasks are falling behind.

Inspector's evidence

On the day of inspection there were two part-time qualified dispensers, one recently recruited part-time technician, three part-time trainee dispensers, one of whom had the role of assistant store manager, and two part-time trainee counter assistants. The regular pharmacist was no longer working in the pharmacy and the pharmacy used a mixture of employed relief pharmacists and locums. The pharmacy had opened forty-five minutes late on the day of inspection. This was due to not having a pharmacist available. The pharmacy had displayed a sign clearly to communicate with people stating when the pharmacy would open. And team members were available to communicate with people about the closure if needed. The pharmacy had recruited several new team members in the past four months. The assistant manager explained that it had been challenging to recruit new team members to replace those who had left recently. The more experienced team members reported regularly working extra hours to help cope with the workload. There were six team members currently undertaking training for their roles. This meant there was limited qualified staff to help the pharmacy to operate safely and effectively. And a lack of regular pharmacist to support trainee team members with tasks they were undertaking. The assistant manager explained plans to allow training team members to work in a quieter pharmacy within the company to obtain experience. This meant swapping hours with a trained team member to cover the pharmacy. But this had not been arranged yet. Team members seen during the inspection demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. The pharmacy had received recent complaints in connection with long waiting times.

The pharmacy provided team members undertaking accredited courses with planned learning time during the working day to complete coursework and review SOPs. There was currently no planned learning time for team members not undertaking courses. A trainee dispenser was observed being supervised in their role and were able to describe the training plan that they were working through. Team members had not had any recent annual appraisals with a pharmacy manager. So they were not able to identify their learning needs or create development plans.

Experienced team members were observed to work on their own initiative, for example to phone the GP practice to ask about missing prescription items. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. The inspector observed an example of this when a team member consulted the pharmacist for advice on appropriate medicines available for someone who was diabetic. They demonstrated an 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 culture of learning in the pharmacy where they

could share and discuss these mistakes. The pharmacy team discussed incidents and how to reduce risks. The team had occasional team meetings.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

These were large-sized premises incorporating a retail area, and an average-sized dispensary. The back shop area included a separate area for multi-compartment compliance pack dispensing, storage space and staff facilities. The premises were clean, hygienic and generally well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs and sink, and the door closed with an additional curtain which provided privacy. The pharmacy also had a separate area within the consultation room for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. It suitably manages its services to help people look after their health. And the pharmacy team provides appropriate advice to people about their medicines. The pharmacy correctly sources its medicines, but it does not always follow a robust process for checking the expiry dates. So, there is an increased risk that some medicines may not be fit to use.

Inspector's evidence

The pharmacy had good physical access by means of level entrances from the shopping centre and directly from the car park. And the central pharmacy counters were low in height so people using wheelchairs could use them. The pharmacy advertised some of its services and its opening hours in the main window. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. 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.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. Team members used various laminated cards to attach to bags containing people's dispensed medicines. 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 CD that needed handing out at the same time. 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 usually assembled items that were owed later the same day or the following day. A team member prepared the prescriptions due for delivery that day and kept a record of the scheduled deliveries. This was useful if people called the pharmacy asking about their expected delivery. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these on a weekly basis in advance of people collecting. They kept records of when people had collected their medicines. And requested new prescriptions appropriately when the prescription was complete.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The pharmacy managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person for each week of assembly. These master sheets documented the person's current medicines and administration time. Some folders had notes of previous changes to medication, creating an audit trail of the changes. This was in the form of written confirmation such as copies of discharge letters from hospital or record of change sheets from the person's GP. Packs were labelled so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored alphabetically in individually named files on specific shelves within the dispensary.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher risk medicines including valproate, methotrexate, lithium, and warfarin. People were supplied with written information and record books if required. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. But they did not know where the written information was kept. They gave assurance that it would be located, or a new pack ordered and kept in an accessible place. They demonstrated the advice they would give in a hypothetical situation, including checking people were enrolled on a pregnancy prevention programme if they fit the inclusion criteria. And ensuring such people used appropriate contraception. They did not record these interventions on the patient medication record (PMR). The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and treatment of urinary tract infections. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the 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. Pharmacy team members were trained to provide a smoking cessation service. They carried out a consultation with people in the consultation room before providing advice. The pharmacist checked that any recommended products were appropriate before supply.

The pharmacy obtained medicines from recognised suppliers. The pharmacy stored medicines in their original packaging on shelves and in drawers. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. The pharmacy had a procedure for checking medication expiry dates. It had a plan to check stock on a rolling three-month cycle. And team members used yellow stickers to highlight short-dated medicines. But the team had fallen behind with date checking stock and removing out-of-date medicines from the shelves. Some sections had not been checked for over six months. There was a basket observed on a dispensing bench containing out-of-date medicines that had been removed from the shelves, but had not yet been destroyed. The expiry dates on these products ranged over a period of four months. Three out-of-date medicines were found by the inspector after a random check of 15 randomly selected medicines on the shelves. Team members explained they checked expiry dates at point of dispensing to help reduce the risk of supplying out-of-date medicines. The team recognised they were behind with the date checking process and had plans to address it. The pharmacy had disposal bins for expired and patient-returned stock. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. They signed and dated the documents to show who had completed any actions required. 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 to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had internet access allowing access to a range of further support tools.

The pharmacy kept some equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy used a manually operated pump for measuring doses on a weekly basis. Team members cleaned it at the end of each day and poured test volumes before using to confirm accuracy. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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.