General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Post Office Buildings, High Street, BEAULY, Inverness-Shire, IV4 7BT

Pharmacy reference: 1042136

Type of pharmacy: Community

Date of inspection: 17/10/2019

Pharmacy context

This is a community pharmacy in the centre of Beauly. It dispenses NHS prescriptions including supplying medicines in multi-compartmental compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines. It also offers a smoking cessation service.

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 team members work to professional standards. They provide safe services and look after people's welfare. The pharmacy keeps records of mistakes when they happen. And there is ongoing service improvement. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means that they listen to people and put things right when they can.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The ACT took extra steps to make sure the near-misses were recorded. And she returned the medication to be corrected, together with the near-miss record sheet for the dispenser to complete at the time. The team members recorded near-miss records. But, they did not always provide a reason for the error other than being busy. The ACT carried out the monthly near-miss review. And discussed the findings with the pharmacy team. The ACT used the near-misses as a training tool to support trainees. For example, she had provided extra support when a trainee had mixed up Spiriva/Spiolto inhalers on two separate occasions. The ACT had reminded team members about the extra care needed when dispensing medication for children. And had planned to discuss the subject again due to an article in the current edition of the professional standards newsletter. The pharmacy produced recent near-miss reports. And a sample showed the following improvement action;
1. Completing the pharmacist information form (PIF) at the time of labelling to highlight new prescriptions.
2. Highlighting look-alike sound-alike (LASA) medication on the PIF.
3. Separating quetiapine and quinine due to selection errors.

The pharmacy team used the company's list of LASA medication to manage dispensing risks. And they kept the list beside the PMR, and used shelf-edge caution labels to highlight LASA stock, such as amitriptyline and allopurinol. The team members confirmed that this had been successful. And that the number of selection errors had reduced. The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about an error involving Movicol regular being supplied against a prescription for Movicol Paediatric. And they had separated the products to avoid a similar error in the future. The pharmacy team used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used a practice leaflet to inform people about the complaints process and who to contact should they wish to complain or provide feedback. The pharmacy received mostly positive comments. And there were no examples of change in response to feedback.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was up-to-date and valid. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy provided a delivery service. And made sure that people signed for their medication to confirm receipt. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample trimethoprim PGD was valid until October 2020.

The pharmacy displayed a 'fair data processing notice' which provided people with information about its data protection arrangements. But, this was behind the medicines counter and not visible from the waiting area. The pharmacy trained team members on an annual basis to comply with data protection arrangements. And they knew how to process and safeguard personal information. The pharmacy disposed of confidential information in designated bags which the company uplifted for off-site shredding. And they archived spent records for the standard retention period.

The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. And the company had registered the pharmacists with the scheme. The company trained the pharmacy team to comply with safeguarding arrangements. And provided contact details so that team members knew who to contact if they had a concern about a child or an adult. The pharmacy displayed a chaperone notice on consultation room door. And it advised people that they could be accompanied whilst in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced a slight growth in the number of NHS prescription items dispensed over the past year. But, the number of team members had reduced due to a pre-registration pharmacist not taking up their post. The accuracy checking technician (ACT) had worked alongside the regular pharmacist for many years. But, most of the other team members were relatively new into post and were not as experienced. The ACT and the pharmacist had been trying to support the trainees through protected learning time. But, they had found this challenging due to the number of changes. A locum pharmacist was providing cover for the regular pharmacist who was on annual leave. And she needed little support due to having been the pre-registration pharmacist at the branch the previous year.

The company managed annual leave requests. And team members were required to submit their annual leave requests in October for the following business year. The pharmacy authorised annual leave for one team member at a time. And a planner was used so that the pharmacist arranged cover or reprioritised the workload if needed. A relief dispenser had been providing some holiday cover. And this was due to new team members already having their holidays booked before they were appointed. The relief dispenser had been moved to another branch. And this was due to another branch that needed support. A part-time dispenser was working extra at the time of the inspection. And this was due to the regular pharmacist’s leave and the pharmacy team being a few days behind with routine dispensing.

The pharmacy kept the team member's training qualifications on-site. And the following were in post; one full-time pharmacist, one part-time accuracy checking technician (ACT), one part-time medicines counter assistant (MCA), one full-time trainee dispenser, three part-time dispensers and one delivery driver. The team members had modified the company’s model-day to better suit their needs. And they met each morning to discuss priorities and reschedule tasks when needed, for example when people were on holiday. The ACT checked progress throughout the day. And this made sure that team members were on track. And if not, tasks were re-prioritised. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had provided feedback that pharmacist information forms (PIFs) occasionally went missing. And they had suggested adding adhesive, so they could be attached to prescriptions.

The pharmacy used a performance review to identify areas for development. For example, the ACT had agreed to lead on patient safety within the branch. And she was responsible for carrying out the monthly near-miss review and leading discussions with the pharmacy team. A dispenser had agreed to spend more time working in the dispensary to develop her performance. And, she was trying to balance

her time between working on the medicines counter and in the dispenser during the 10 hours that she worked each week.

The company provided a range of training resources. And the team members were up-to-date with the company's mandatory training requirements. For example, they had recently completed training which aimed to improve the customer's experience. One of the dispensers had completed a training module about foot problems. And had learned that foot soles were uncomfortable at first. The dispenser had applied the learning. And had been able to advise people to expect insoles to be uncomfortable at first but to persevere. The ACT attended away-day training day every year along with her peers at an off-site location. And patient safety had been an agenda item in June 2019. The pharmacy used the company's patient safety initiative to identify risks. But, the team members did not always reflect and document the reasons for near-misses. And this prevented them from learning from their mistakes.

The pharmacy used performance targets to grow services. And team members were currently focussed on identifying suitable people for the chronic medication service (CMS). The team members knew that CMS supported people to take their medicines as intended. And, it also helped them to manage their workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided seating and healthcare information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And team members dispensed multi-compartment compliance packs in a separate room at the rear of the pharmacy. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room, and this was professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist mostly keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had a stepped entrance. And a portable ramp was available should it be needed. The pharmacy used a pressure activated door. And a bell at the outside of the pharmacy provided support to people with mobility difficulties. The team members had arranged to provide extra support to someone who used a wheelchair. And handed over their medication at the door. The pharmacy displayed its opening hours in the window. And it displayed healthcare information leaflets in the waiting area and in the consultation room. The dispensing benches were organised. And the pharmacy team used dispensing boxes to keep prescriptions and medicines contained throughout the dispensing process.

The pharmacy dispensed multi-compartment compliance packs for around 40 people who needed extra support with their medicines. And the pharmacy team had read and signed a valid SOP to ensure that dispensing was safe and effective. The team members used trackers to manage the work-load. And this supported them to dispense medication in time. The team members isolated packs when they were notified about prescription changes. And kept a record of changes in the communications book and a copy in the patient's notes. The team members supplied patient information leaflets. And they annotated descriptions of medicines inside the pack. The team members asked their colleagues to check packs at the time of supply. And a docket was completed once the supply was made. The team members used magazine boxes to store packs. And they turned the boxes to face the wall when people collected their pack. This helped them to identify missed collections. And prompted them to contact carers or the GP practice to check if support was being provided or needed.

The ACT and the pharmacist spoke to people about their medication. And they registered suitable people with the chronic medication service (CMS) to support them to take their medicines as intended. The team members used trackers to dispense prescriptions before they were due. And they contacted people who failed to collect their medication on time. This helped to identify compliance issues which they then tried to resolve.

The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The pharmacy held stocks of medicines used in palliative care. And team members carried out regular balance and date checks to ensure that medicines were available for use. The team members kept the pharmacy shelves neat and tidy. And kept controlled drugs in two well-organised cabinets. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs during regular expiry date checks. The team members monitored and recorded the fridge

temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius.

The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected. The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked for Xonvea in October 2019 with no stock found. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team had not been briefed about its use and when it was due to be introduced.

The ACT had learned about the valproate pregnancy protection programme. But one of the dispensers did not know about the initiative and where to find the safety leaflets and cards. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to confirm that people had been provided with safety messages.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. And the measure for methadone was highlighted and kept in the controlled drug cabinet when no-one was registered with the service.

The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.