General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 11-1 East Gate Shopping Cnt., East Gate, INVERNESS, Inverness-Shire, IV2 3PP

Pharmacy reference: 1042146

Type of pharmacy: Community

Date of inspection: 15/11/2019

Pharmacy context

The pharmacy is in the town centre of Inverness. It has long opening hours. And it opens on a Saturday and a Sunday. The pharmacy dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a repeat prescription collection service and a medicines' delivery service. The pharmacy advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines. The pharmacy provides dispensing services and advice to care homes. And it offers smoking cessation and vaccination services.

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	Good practice	1.2	Good practice	The pharmacy embeds continuous improvement in its culture. The pharmacy team ensures it learns when things go wrong. And it takes its time to discuss and identify risks so that the safety and effectiveness of its services continue to improve.
		1.7	Good practice	The pharmacy has a systematic approach to information governance. It provides regular training. And it carries out regular reviews to confirm that its arrangements meet data protection requirements.
		1.8	Good practice	There is a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages it services well. The pharmacy team members are organised and efficient. And they provide safe services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team members work to professional standards. And they keep good records about mistakes when they happen. The team members discuss the mistakes at regular meetings. And this helps them to make safety improvements to keep services safe. The pharmacy keeps the records it needs to by law. And it provides regular training for the team to keep confidential information safe. The team members understand their role in protecting vulnerable people. People using the pharmacy can raise concerns. And the pharmacy team members know to follow the company's complaints handling procedure. They listen to people and put things right when they can. And make service changes to improve people's experiences.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The pharmacy 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 responsible pharmacist mostly worked in the downstairs dispensary. And a second pharmacist worked in the upstairs dispensary. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacists and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacy used separate records for near-misses; one for care home and multi-compartment compliance pack dispensing. And another for repeat and walk-in dispensing. The pharmacy kept good near-miss records which continued to improve. And the pharmacy teams were currently working to provide more information about the reasons for their errors. This was improving the quality of near-miss reviews. And it was helping the pharmacy team to identify where it needed to make safety improvements. The pharmacists carried out the monthly near-miss reviews. And they provided a documented analysis of the findings which they shared with the pharmacy teams.

A sample of near-miss reports showed that safety measures had been introduced and were having an impact at managing risks. For example, a look-alike and sound-alike (LASA) initiative had reduced the number of near-misses. The team members referred to a list of LASA medicines. And knew to take greater care when they saw shelf-edge caution labels, such as when selecting amlodipine and allopurinol tablets. The team members knew to record LASAs on the pharmacist information form. And this also alerted colleagues to the risk of errors. The pharmacy team had agreed not to interrupt colleagues when they were processing care home prescriptions using the PMR. And this had reduced the number of labelling errors. The pharmacist had identified 'quantity errors' as a recurring cause of errors. And they were providing one-to-one support when team members were responsible for an unacceptable level of errors. The pharmacists had identified 'jumping' tablets as a cause of errors. And the dispenser had agreed to take more care when transferring multi-compartment compliance packs to the checking bench.

The pharmacists managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about an incident when a faxed interim prescription had been dispensed and supplied to the care home twice. And the

pharmacy team had been reminded to check the PMR when dispensing interim prescriptions. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it provided information about the complaints process in a leaflet that was being displayed in the waiting area. The pharmacists had reviewed the booking process that was used for flu vaccinations. And they had briefed the team members so they knew to check the rota to make sure the pharmacist was accredited to provide the service. The pharmacy team members had listened to feedback from a care home. And they had re-arranged their schedule so the care home staff had more time to check and sort prescriptions at the time of delivery.

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 this was valid and up to date. 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 held stock of drugs used in palliative care medicine. And an agreed stock level was frequently checked to ensure stock was available. 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 pharmacist had contacted the controlled drugs accountable officer at the health board following receipt of a large quantity of broken/leaked methadone bottles. And they had securely packaged and quarantined the affected stock in the bottom of the controlled drug cabinet. The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for controlled drugs 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 had been accredited to use patient group directions to improve access to medicines and advice. And sample trimethoprim and hepatitis PGDs were valid until 2020.

The pharmacy did not display information about its data protection arrangements. But, the pharmacists provided tailored information when they provided professional services such as vaccinations. The pharmacy trained team members on a regular basis to comply with data protection arrangements. And they knew how to safeguard personal information. The pharmacy disposed of confidential information in designated bags. 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 pharmacy 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 a vulnerable adult. The company had trained its team members to recognise the signs and symptoms of dementia. And they knew when to refer to the pharmacist. For example, the same dispenser handed out multi-compartment compliance packs. And they spoke to people to make sure they were taking their medicines as intended.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably qualified pharmacy team members throughout the week. The pharmacy encourages the pharmacy team to develop. And it provides protected time in the work-place for them to learn. This ensures the team members keep up to date in their roles. The pharmacy team members support each other in their day-to-day work. And they speak up at regular meetings so that services continue to improve.

Inspector's evidence

The pharmacy had experienced a slight decrease in the number of NHS prescription items it dispensed. The base pharmacist carried out regular reviews. And they confirmed the pharmacy team had the capacity and capability to provide its services. The pharmacist was reviewing the dispensing services. And they were consulting with other team members to decide if they could dispense repeat prescriptions in the upstairs dispensary. The pharmacy had trained and accredited a pharmacy technician to carry out accuracy checks. And they were about to replace an ACT that was leaving. The pharmacy had more team members than the company's recommended levels. And it was deciding whether it needed to replace the team member who was about to replace the ACT who was leaving. The team members did not feel undue pressure to achieve the service targets that had been set. For example, the company had not placed pressure on the pharmacy team following a reduction in the number of care homes its serviced.

The pharmacists had worked at the pharmacy for a significant length of time. And four regular pharmacists provided 104 hours cover over the 67 hours that the pharmacy opened. The pharmacy employed regular relief pharmacists to provide extra cover when needed. For example, to support the regular pharmacists to provide flu vaccinations. Most of the team members had worked at the pharmacy for many years. And they were experienced and knowledgeable in their roles. The pharmacy kept the team's qualifications on-site. And the following people were in post; one part-time accuracy checking technician, one full-time trainee pharmacy technician, three full-time dispensers, six part-time dispensers and one full-time medicines counter assistant. The pharmacy employed six full-time store managers. And they had completed the necessary training to enable them to work in the dispensary when cover was needed. The base pharmacist used rotas to ensure the pharmacy had the right number of suitably qualified team members throughout the week. And the team members worked Monday to Sunday to provide service continuity at the weekend. The base pharmacist authorised annual leave. And they ensured that minimum levels were maintained. The base pharmacist identified when there were gaps. And they booked relief dispensers to ensure that cover was provided.

The company used an annual appraisal to identify areas for development. For example, one of the dispensers had been supported to enrol on the NVQ pharmacy service level 3 course so they were eligible to register as a pharmacy technician. The company was supporting the base pharmacist to undergo the pharmacist independent prescriber course. And it had arranged off-site training for the regular pharmacists, so they were accredited to provide the travel vaccination service. The base pharmacist supported others to complete training. And they had allocated protected training time in the workplace so there was satisfactory progress with courses. The company provided regular training to ensure that team members were competent in their roles. And the team members were up-to-date

with the company's mandatory requirements. For example, they had completed safeguarding and information governance training in the last year. The pharmacy had arranged for the health board to provide on-site smoking cessation and needle exchange training due to service demands. And this had provided the knowledge and skills to provide the services, such as information about injection sites and needle sizes. The pharmacists and the pharmacy technicians attended off-site training a few times a year. And the company provided updates on standing items, such as patient safety initiatives.

The team members had completed on-line training so they knew how to maintain a no-blame culture in the pharmacy. And they felt empowered to raise concerns and provide suggestions. For example, one of the dispensers had started assembling the kits for drug-taking when the health board had made changes to its supply arrangements. This had been brought to the attention of the health board who adopted the practice due to the financial savings that were possible.

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 it 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 two dispensaries. And it had allocated areas and benches for the different dispensing tasks. For example, the team members used shelves for prescriptions awaiting a final accuracy check. And this managed the risk of the benches in the downstairs pharmacy becoming too congested. The pharmacist supervised the medicines counter from the checking bench. And they 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 a separate hatch. And both were 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 about its extended opening hours and the services that 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 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 step-free entrance. And an automatic door supported people with mobility difficulties. The pharmacy displayed opening hours in its window. And displayed healthcare information leaflets in the waiting area and in the consultation room. The pharmacy had identified that a significant number of Chinese people used the pharmacy. And it provided leaflets to meet their language needs. The pharmacy had re-designed its queuing system so that people registered with its prescription texting service could collect their medication more quickly using an ‘express’ lane. And this had led to improvements in how the team members managed their work-load. And it had freed up time for other duties.

The practice pharmacists registered people with the chronic medication service (CMS) at the surgeries. And the pharmacy team dispensed serial prescriptions for around 300 people. The team members kept the prescriptions separate. And they used trackers to dispense them around seven days before medication was due. The pharmacist monitored when people collected their prescriptions. And this identified people who were not taking their medicines as intended. For example, one of the team members had referred someone who reported feeling light-headed. And the pharmacist had intervened to find out the cause. The pharmacists attached laminated cards to prescriptions bags containing high-risk medicines. For example, to highlight the risks associated with taking warfarin. And the team members knew to use the questions on the back of the card to make sure people were having the checks they needed to.

The pharmacy supplied multi-compartment compliance packs for around 65 people. And the team members had read and signed the working instructions to ensure dispensing was safe and effective. A lead dispenser was responsible for dispensing the packs. And the rest of team had been trained and accredited to provide cover when needed. The team members used trackers to ensure they carried out dispensing in time for the next supply. And they isolated packs when they were notified about prescription changes which they noted in the communications book and in the person’s notes. The team members knew to add medication such as sodium valproate and nicorandil on the day of delivery or collection. And this was due to the stability of the medication. The pharmacy supplied patient information leaflets and provided descriptions of medicines. And this supported people to take their medicines. The pharmacy team dispensed methadone doses once a week for around 12 people. And they obtained prescription checks at the time of dispensing and at the time of supply.

The pharmacy dispensed prescriptions for people in care homes. And a dedicated upstairs dispensary was used. A dedicated pharmacy team worked in the dispensary. And a full-time dispenser managed

the operations. The base pharmacist provided clinical support. And they provided accuracy checks alongside the ACT. The pharmacy team members used planners to manage the work-load. And the lead dispenser used rotas to ensure that minimum levels were maintained throughout the week. The pharmacy team members carried out the necessary checks on receipt of the prescriptions. And they documented relevant information on the pharmacist information form, for example, people who had allergies. The team members ordered the required stock at the time they processed the prescriptions. And they dispensed straight from the order as soon as it arrived in the pharmacy. The care home dispensary was well organised with separate areas for interim prescriptions and for carrying out the final accuracy checks.

The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The team members kept the pharmacy shelves neat and tidy. And kept controlled drugs in two well-organised cabinets to manage the risk of dispensing errors. For example, they kept sugar-free and sugar-containing methadone in separate cabinets. The team members carried out regular stock management activities. And they highlighted short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. 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 accepted returned medicines from the public. And it used yellow containers to dispose of the waste that the health board later collected. The pharmacy team used designated containers for the disposal of spent methadone bottles. And the company uplifted the containers for destruction at a central location. The pharmacy team members acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked for adrenaline pre-filled syringes on 6 November 2019, with no stock found. The pharmacy team members had completed e-learning and they knew about the valproate pregnancy protection programme. And where to find safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to highlight people that were affected. The pharmacy team had been trained about the Falsified Medicines Directive (FMD) and what it aimed to achieve. But the company had not yet introduced system. And the team members did not know when it was due to be implemented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the pharmacy team members keep the equipment clean and maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and Medicines Complete. It used crown-stamped measuring equipment. And the measures for methadone were highlighted and separated, so they were used exclusively for this purpose. 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 were able to take 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.