

Registered pharmacy inspection report

Pharmacy Name: Boots, 97 King Street, CASTLE DOUGLAS,
Kirkcudbrightshire, DG7 1LZ

Pharmacy reference: 1042177

Type of pharmacy: Community

Date of inspection: 21/09/2022

Pharmacy context

This is a community pharmacy in the centre of the town of Castle Douglas, Kirkcudbrightshire. The pharmacy sells over-the-counter medicines, dispenses NHS and private prescriptions. And it delivers medicines for some people to their homes. The pharmacy supplies some people with their medicines in multi-compartment compliance packs to help them take their medicines. It also offers the NHS Pharmacy First 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 has up-to-date processes in place to help the pharmacy team effectively and safely manage the risks with the services it provides for people. Team members keep the records they need to, and they keep people's private information safe. The team has the knowledge to help protect vulnerable people who use the pharmacy. Team members discuss and record details of mistakes they make while dispensing. And they review them to help make changes to the way they work to improve patient safety.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These provided information to help team members carry out various tasks, including dispensing and record keeping. Team members described their roles within the pharmacy and the processes they were involved in. Some, but not all team members had read and understood the SOPs relevant to their roles. Some team members had signed a document to confirm they had read and understood the SOPs. The pharmacy had reviewed the SOPs in 2021. They were scheduled to be reviewed every two years. This was to make sure they were up to date and accurately reflected the pharmacy's current practices.

The pharmacy had a process to record and report mistakes made by team members during the dispensing process. These were known as near misses. Team members used a near miss log to help them record near misses. They recorded several details including the type of near miss and the date and time the near miss happened. Team members recorded the reason why a near miss might have happened. And how they could prevent a similar mistake from happening again. The team reported not all near miss errors had been recorded over the last few months as they were often busy completing other tasks. Team members took turns to analyse the near misses to look for any trends or patterns. And they did this each month. They documented their findings in a written report. The report was kept in the dispensary for future reference. Recently, the team had noticed several near miss errors involving team members dispensing the incorrect form of medicines. For example, selecting capsules instead of tablets. To improve, they decided to make sure they highlighted on prescriptions the form of medicines when there were different forms. The pharmacy used an electronic reporting system to record any dispensing errors that had reached people. The pharmacy retained a copy of the report for future reference. Details of any dispensing errors were also shared with the pharmacy's area manager and superintendent pharmacist (SI) team. The pharmacy had a concerns and complaints procedure. 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 up-to-date professional indemnity insurance. It had a responsible pharmacist (RP) notice on display which displayed the RP's full name and GPhC registration number. Entries in the RP record were kept in line with legal requirements. The pharmacy kept records of supplies against private prescriptions. It kept controlled drug (CD) registers, and to make sure they were accurate, each week the pharmacy audited CD registers against physical stock. During the inspection, the balance of a randomly selected CD was checked. The balance was correct. The pharmacy kept up-to-date records of the destruction of out-of-date CDs and CDs that had been returned to the pharmacy by people.

The team held most records containing personal identifiable information in areas of the pharmacy that

only team members could access. The team placed confidential waste into separate blue sacks to avoid a mix up with general waste. The waste was periodically destroyed. The pharmacy had a procedure to help the team raise any concerns team members may have about the safeguarding of vulnerable adults and children. There was a notice affixed to a wall in the dispensary which displayed the contact details of local support teams. And team members described hypothetical safeguarding situations that they would feel the need to report. The RP and the pharmacy's manager had membership with the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members have the skills and qualifications to effectively provide the pharmacy's services. The pharmacy supports its team members in keeping their knowledge and skills up to date. And it supports them to make changes to improve the way the pharmacy operates. Team members feel comfortable in raising professional concerns and giving feedback.

Inspector's evidence

At the time of the inspection the RP was a locum pharmacist. The RP was supported by a part-time trainee dispenser and four full-time qualified dispensers. One of the dispensers was also the pharmacy's manager and was responsible for additional administrative duties. The pharmacy also employed another full-time qualified dispenser and a part-time delivery driver. The pharmacy didn't employ a regular pharmacist and had not done so since December 2021. So, the pharmacy was using locum pharmacists. Team members explained that this had been challenging and were looking forward to the pharmacy finding a full-time pharmacist to fill the vacant position. Team members covered each other's planned and unplanned absences. Team members were working well together, and they were seen dispensing prescriptions without any significant time pressures. Team members were supervised by the RP while they worked. They were observed asking appropriate questions when selling over-the-counter medicines to people and they were aware of what could and could not happen in the RP's absence.

Team members were encouraged to improve their skills and further their professional development. This was done through protected training time which was authorised by the pharmacy manager. Each team member had access to a library of healthcare related modules via an online portal. They could select a module they wished to complete, and some had short quizzes for team members to complete to assess their understanding. Some modules were mandatory to complete. For example, recently the team were asked to complete a module relating to the sale of a new over-the-counter contraceptive. The pharmacy kept records of each team members training and they were encouraged to complete any overdue modules as soon as possible. The pharmacy had an annual appraisal process which was due to be completed within the next few weeks.

Team members were invited to attend team meetings during which they discussed workload and how they could improve the way they worked to improve patient safety. They had recently discussed a series of near misses involving medicines where the packaging looked similar or had similar names. Team members were encouraged to provide feedback on the delivery of the services the pharmacy provided to people. They explained that they would generally provide feedback to each other through open, informal conversations. Recently the team had decided to use a segregated part of the dispensary to manage stock for prescriptions that were due to be collected by people the next day. This helped them dispense away from the retail area without distractions and dispense in a larger space which helped reduce the risk of mistakes being made. The pharmacy had a whistleblowing policy in place to help team members anonymously raise professional concerns. The team had targets to achieve but team members didn't feel under pressure to achieve them and focused on providing a good service to the local community.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and secure. And its premises are suitable for the services it provides. It has a suitable consultation room where people can have private conversations with team members.

Inspector's evidence

The pharmacy was clean, well maintained, and professional in appearance. Benches were kept tidy and well organised. The pharmacy's floor space was clear from obstruction. 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. The pharmacy had plenty of space to store its medicines. There was a large, private, soundproofed consultation room available for people to have private conversations with team members.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled public access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy team manages and delivers the pharmacy's services well. And it makes its services easily accessible to people. The pharmacy sources its medicines from recognised suppliers, and it completes regular checks of its medicines to make sure they are suitable to supply.

Inspector's evidence

People had level access into the pharmacy through the main entrance door. The door had a push button automatic opening mechanism. This made it easy for people with wheelchairs or pushchairs to enter the pharmacy. There was some public car parking directly outside the pharmacy for people to use. The pharmacy advertised its opening hours on the main entrance door. The pharmacy was closed each day between 1pm and 2pm. But this wasn't accurately displayed on the pharmacy's information section on the Boots website, or on the NHS Inform website. Team members were aware this may cause confusion for some people. The pharmacy provided large print labels to people with a visual impairment. And it had a hearing induction loop, but team members were unsure how to use it. Team members had access to the internet which they used to signpost people requiring services the pharmacy didn't offer. The pharmacy had a large selection of healthcare related information leaflets for people to take away with them. 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. 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. The pharmacy provided the NHS Pharmacy First service. All team members were trained to provide the service. The pharmacy had an up-to-date formulary to help the team consider which treatments would be suitable for people. Team members usually undertook consultations with people in the pharmacy's consultation room. And they completed relevant paperwork. The pharmacist felt confident in the team's ability to appropriately counsel people and explained team members always involved the pharmacist if they were unsure. For example, if a person was taking other medicines for other conditions.

Team members used laminated cards as an alert before they handed out medicines to people. For example, 'speak to pharmacist' laminates 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 signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of different people's medicines from being mixed up. They used Pharmacist Information Forms (PIFs) to document any relevant information for the RP, to help them complete the final check of the medicines. For example, if the person would benefit from any additional counselling. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and it kept records of the service to use as an audit trail.

The pharmacy supplied medicines in multi-compartment compliance packs to several people. The team dispensed the packs in a segregated part of the dispensary. This helped team members dispense the packs away from the retail area to reduce the risk of distractions. They spread the workload over a four-week cycle. This helped the team manage the workload more evenly. Team members used master sheets which contained a list of the person's current medication and dose times. And they checked

prescriptions against the master sheets before the dispensing process started to make sure they were accurate. Team members discussed any queries with the relevant prescriber. They recorded details of any changes such as dosage increases or decreases on the person's master sheet and their electronic medication record. The pharmacy supplied people receiving the packs with patient information leaflets. The packs were supplied with descriptions of the medicines to help people identify them. For example, 'orange, round, tablet'.

The pharmacy stored pharmacy (P) medicines behind the pharmacy counter. It stored other medicines in their original packaging on shelves and in drawers. The pharmacy had a process in place for the team to check the expiry date of the pharmacy's medicines. Team members highlighted any medicines that would expire within six months by attaching alert stickers to the packaging. The pharmacy kept records of the completion of the process. And so, there was an audit trail in place. No out-of-date medicines were found after a random check of around 25 randomly selected medicines. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It used a clinical grade fridge to store medicines that needed cold storage. The team recorded the temperature ranges of the fridge each day. And a sample of the records showed the fridge was operating within the correct ranges. The pharmacy received regular updates via email of any drug alerts and recalls. Team members recorded the action they took following an alert.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services. And it uses its equipment properly to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. It stored dispensed medicines awaiting collection in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in a private area. Team members had access to personal protective equipment including face masks and gloves.

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.