General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 85-87 High Street, LANARK, Lanarkshire, ML11 7LN

Pharmacy reference: 1042560

Type of pharmacy: Community

Date of inspection: 15/08/2019

Pharmacy context

The pharmacy is in the town centre of Lanark. It dispenses NHS prescriptions and provides a range of extra services. The pharmacy collects prescriptions from the local surgeries. And offers a delivery service to housebound and vulnerable people. It supplies medicines in multi-compartmental compliance packs when people need extra help taking their medicines. And it provides dispensing services and advice to local care homes. Consultation facilities are available, and people can be seen in private.

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 pharmacy team consistently records near misses and dispensing incidents. And internal and external audits are carried out on a regular basis. The pharmacy uses the information to identify areas for improvement. And this ensures that services continually improve and develop. The pharmacy team meets regularly to discuss the findings. And this ensures that team members are aware of the risks in the pharmacy and take responsibility for implementing improved safety measures.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members take ownership of tasks. They plan and complete regular training to improve their knowledge and skills. And they take the opportunity to provide feedback so services develop, and patient safety can improve. The team members support each other. And ensure trainees are confident in their roles. There is a culture of openness, honesty and learning.
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 complete training and work to professional standards. They keep good records when mistakes happen. And senior pharmacy team members carry out checks to make sure the pharmacy is running safely. The pharmacy team members discuss the need for improved safety measures. And they are proactive at identifying risks and making service improvements. 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 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 pharmacy used two separate records for near-misses and the level of recording was consistent each month. This ensured the pharmacy team identified the risks in the upstairs care home dispensary and the downstairs dispensary that was used for the other services. The dispensers recorded their own near-misses. And provided the reasons why they thought the mistakes had happened. A trainee pharmacy technician in the downstairs dispensary and an ACT in the upstairs dispensary analysed the data at the end of each month. And they recorded improvement actions following monthly discussions with team members. Sample reports confirmed they had introduced improvements, such as underlining quantities to confirm they had dispensed the correct number of doses. And asking colleagues to check and sign medicines labels before passing to the pharmacist for a final accuracy check. The upstairs pharmacy team had identified that near-misses increased when other dispensers provided cover. And this was due to them not updating medicines descriptions on multi-compartmental compliance packs when required. And this had been highlighted as a training need.

The company used external auditors to carry out checks. And to highlight areas for improvement. For example, the pharmacy team members had been notified they needed to undergo Turas training, so they had the knowledge and skills to identify and manage safeguarding issues. The pharmacist and the ACT had been authorised to manage the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew the delivery driver had delivered the wrong medication to a care home. The team members had discussed the error. And had agreed to provide more detailed instructions when handing over bags for delivery and to check understanding. The pharmacist had also informed the distribution centre who were responsible for

managing the delivery service.

The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And although the company supplied leaflets to inform people about the complaints process. These were being kept in the consultation room where access was restricted. The pharmacy team investigated and responded to complaints. For example, when someone complained their owing was not available. The pharmacist met with the complainant and explained that the prescription had been removed due to the length of time it had been waiting on the shelf. The pharmacist believed the person had been satisfied with the response. And the complaint was discussed amongst the team. The team members had agreed to attach the company's owings slip to the prescription. And to confirm that people were informed about the collection deadline to manage expectations. The team members issued information cards that encouraged people to provide feedback. And this was mostly positive with no suggestions for improvement.

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 team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The methadone prescription records were reviewed at the end of the day. And this identified people who had not attended for the supervised consumption of methadone doses. 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 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 completed Turas training. And had been accredited to use patient group directions to improve access to medicines and advice. A sample trimethoprim patient group direction was valid until November 2019. The pharmacy had public liability and professional indemnity insurance in place and this was up to date.

The pharmacy displayed a 'fair data processing notice' which provided people with information about its data protection arrangements. 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 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 pharmacy team recognised the signs and symptoms of abuse and neglect. And knew when to refer to the pharmacist. For example, the pharmacist asked someone to return at a later time to collect their methadone dose. And this was due to the person smelling strongly of alcohol.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it 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 not experienced any significant growth over the past year. And the work-load had remained mostly the same. The pharmacy used performance targets. For example, the pharmacy team was focussed on offering a text service. And this notified people when their prescriptions were ready for collection. The pre-registration pharmacist was about to train team members to speak to people about the chronic medication service (CMS). And once deemed competent they would be authorised to support people to complete a questionnaire about their medicines and refer issues to the pharmacist. The pharmacy team did not feel undue pressure to register people with the services they provided.

Most of the dispensers had worked at the pharmacy for many years. And were experienced and knowledgeable in their roles. The company recognised the pharmacy as a two-dispensary practice. And as a result, provided a second pharmacist half-a-day a week to carry out clinical checks on care home prescriptions. The company also provided a relief accredited checking technician (ACT) when the ACT was on leave. The pharmacy technician/care home manager was about to take up a position in another Boots branch. And the non-pharmacist manager was interviewing for a replacement at the time of the inspection. The pharmacy kept the team's certificates on-site. And the following team members were in post; two part-time pharmacists with second pharmacist cover, one full-time pre-registration pharmacist, one part-time medicines counter assistant, one full-time dispenser (store manager), three full-time dispensers, one part-time dispenser, one full-time trainee pharmacy technician, one full-time pharmacy technician, one full-time accredited checking technician and one Saturday dispenser.

The pharmacy managed annual leave and team members were expected to submit holiday requests a year in advance. The manager regularly reviewed the holiday planner to ensure that cover was arranged in advance. And the pharmacy team budget was calculated to provide internal cover when it was needed. The pharmacy used a wipe-clean board for the model day rota. And this was reviewed every day and updated when team members were on leave. The team members had reviewed the original rota that had been issued. And had tailored it to meet their own needs. The pharmacist and the team members had discussed the need for training to ensure that everyone had the knowledge and skills to work in care home services and the downstairs dispensary. And this aimed to improve flexibility.

The pharmacy used an annual appraisal to identify areas for development. For example, the relief ACT was undergoing a period of re-accreditation to assure competency to work across several branches

including care home services. The ACT knew to look for the pharmacist's signature on a prescription. And this provided the authorisation needed to carry out final accuracy checks. The pharmacy provided regular training. And the team members were currently focussed on reading several new SOPs that had been issued. The non-pharmacist manager and the pharmacist had provided feedback to the area manager about the timing of the new SOPs. And the extra pressure this placed on the pharmacy team during the peak holiday period. And this was accepted and was being escalated.

The pharmacy team completed compliance training. And ensured that team members followed the company's policies and procedures to help provide safe and effective services. The team members had read the current issue of a professional standards newsletter. And had discussed the case study about a dispensing incident involving gabapentin and pregabalin. The team confirmed they had already added the products to their look-alike sound-alike list of high-risk medicines to manage selection risks. A pre-registration pharmacist was employed but was on annual leave at the time of the inspection. A pharmacist mentor supported the trainee. And regular meetings had been arranged to ensure compliance with training standards and to ensure they were supported in the work-place. The pharmacist identified training opportunities. For example, checking the results of an assessment that had been completed by the pharmacy team members to ensure they understood the new SOPs that had been issued. The pharmacist mentored the trainee pharmacy technician. And had completed an expert witness module to provide the necessary quality assurance when evidence had been submitted by the trainee. The trainee pharmacy technician had been allocated an hour's training time in the work-place.

The pharmacy team members felt empowered to raise concerns and provide suggestions. And there were several examples of service improvement. For example, adding local look-alike and sound-alike medicines to the list that was issued by the company. Such as, adding zopiclone and zolpidem following near-miss reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean. And provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided seating and some healthcare information leaflets for self-selection. The pharmacy had two dispensaries and had allocated areas and benches for the different dispensing tasks. The team members dispensed walk-in prescriptions near to the waiting area. And 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 a separate hatch. And both were professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has up-to-date working instructions for its services. And these support the pharmacy team members to work in a safe and effective way. The pharmacy sources and generally manages its medicines well. And stores them safely and securely. The pharmacy manages its services well and they are accessible to people with mobility difficulties. The pharmacy identifies people taking high-risk medicines. So, it can provide these people with extra advice and information. The pharmacy dispenses multi-compartmental compliance packs to support people to take their medicines. And suitably experienced team members provide a dispensing and advisory service to local care homes.

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 a few healthcare information leaflets in the waiting area and in the consultation room. The pharmacist intervened when people were having difficulties taking their medicines. For example, the pharmacist assessed the inhaler technique of people who had poor control over their asthma. And provided education and support and follow-up assessments to confirm their technique had improved. The pharmacy used laminated cards to highlight high risk medication such as lithium, warfarin and methotrexate. And ensured people were attending appointments and having blood tests when necessary. A new clozapine SOP had been introduced. And the pharmacist closely supervised clozapine dispensing to ensure the necessary checks were being carried out.

The pharmacy used a stock segregation system for repeat prescriptions that they managed on behalf of people. And ordered the exact stock which arrived in segregated totes and placed on segregated shelves. The system saved time and highlighted mistakes. For example, when stock was left over further checks were carried out to identify errors. The pharmacy dispensed multi-compartment compliance packs for people who needed extra support with their medicines. And the pharmacy team had read and signed a valid SOP to ensure the process was safe and effective. The pharmacy had temporarily capped the service. And this was due to changes within the pharmacy team that provided the service. The pharmacy team used trackers to manage the work-load. And packs were dispensed on week two and four of the four week cycle to fit in with care home dispensing requirements. 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 pharmacy supplied patient information leaflets and annotated descriptions of medicines in the pack. And took follow-up action when people did not collect their packs or when there were failed deliveries.

The pharmacy provided dispensing services and medicines advice to support local care homes. A self-contained dispensary was used. And a dedicated pharmacy team carried out dispensing activities. An area pharmacist provided the care homes with advice and support to ensure compliance with care home standards. A pharmacy technician managed the care home service. And the pharmacy team used planners to manage the work-load. The company had changed the way it supplied medicines and around 70% of medicines were now dispensed in their original pack alongside medicines administration

records (MAR).

The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for controlled drugs to confirm receipt. The team members had agreed to ask people to confirm their post-code when they arrived to collect their prescriptions. And this managed the risk of hand-out errors. The team members dispensed methadone doses once a week to manage the work-load. And they obtained an accuracy check at the time of dispensing and at the time of supply.

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. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs during regular 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 used a fridge for stock and another for dispensed items awaiting collection. 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 disposed of them in yellow containers that the health board collected. The pharmacy team disposed of spent methadone bottles in a designated container. And this was uplifted and destroyed 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 stock distributed by Kosei Pharma UK Ltd in July with no stock found. The pharmacy team members had completed a learning module, and the pharmacist had carried out checks to ensure they understood the requirements of the valproate pregnancy protection programme. The team members knew where to find safety leaflets and cards. And had been instructed to issue them to female people taking valproate. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to highlight affected people and the shelf edge to highlight stock. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team had not been trained about its use and did not know what the next steps were to be.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it keeps them 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) and Medicines Complete. It used crown-stamped measuring equipment. And the measures for methadone were highlighted in red 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 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.