General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 1, Edinburgh Fort Retail Park, New Craighill Road, EDINBURGH, Midlothian, EH15 3RH

Pharmacy reference: 1042713

Type of pharmacy: Community

Date of inspection: 18/09/2019

Pharmacy context

This is a community pharmacy in a retail park on the edge of a city. The pharmacy dispenses NHS prescriptions, private prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. It offers additional services including vaccinations for travel, flu and other illnesses.

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	1.2	Good practice	The pharmacy comprehensively reviews and learns from mistakes. It keeps records showing what has been done and how that has improved service quality.
2. Staff	Standards met	2.2	Good practice	The pharmacy identifies and addresses team members' training and development needs. It provides time at work for team members to complete training and reading. And it keeps records of all training and learning.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers services relevant to the local community. And it delivers these at times accessible to people.
		4.2	Good practice	The pharmacy team manage their work to ensure efficiency and effectiveness of all services the pharmacy offers. Team members follow robust processes and keep thorough records of service delivery.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team members follow documented processes for all services to ensure they are safe. They record mistakes to learn from them. And they review these, making improvements to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were all clear about the role of medicines counter assistants, and an accuracy checking technician (ACT). The pharmacy managed dispensing, a high-risk activity, well, with baskets used to separate people's medication. Although this was challenging at busy times due to the small size of the dispensary. The ACT mainly accuracy checked managed repeat prescriptions after they had been clinically checked by a pharmacist, denoted by initials. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had a 'pharmacy services governance' folder which was used to ensure all services were safe and followed robust processes.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They each had their own sheet which enabled them to monitor and review their own mistakes. The person checking was responsible for ensuring each incident was recorded. And individuals were encouraged to record their own mistakes when possible. They also recorded errors reaching patients to learn from them. The ACT reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. She completed a monthly review document which was shared with all team members, then displayed on the dispensary wall for reference. A recent review reminded all team members to record all incidents, being vigilant when relief or locum pharmacists were working; all to double check forms and strengths as these had been the most common mistakes recently; and all team members to ensure they were competent at setting up instalment prescriptions. The ACT had reviewed the previous month's actions and reported that there had been no issues handing out prescriptions following improvements made.

The pharmacy had a complaints procedure and welcomed feedback. People were positive about the access to vaccinations, and the services were continually growing. The pharmacy was looking at ways of increasing access to these.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log including advance declarations as required for absence before the pharmacy opened some mornings; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Good filing and record keeping for

services.

Pharmacy team members were aware of the need for confidentiality. They undertook annual mandatory training on information governance and safeguarding. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. They knew how to raise safeguarding concerns locally and had access to contact details and processes. The pharmacy kept this information in a folder also containing the contact details of all surgeries in the area, other pharmacies and other relevant stakeholders. All team members had recently read safeguarding information provided by head office.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications with services and how busy the pharmacy is. And then makes changes when required. This ensures skilled and qualified staff always provide services. Team members have access to training material to ensure they have the skills they need. The pharmacy helps them identify training needs and gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. Team members can make suggestions and raise concerns to keep the pharmacy safe and improve services. They discuss incidents. And they learn from them to avid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: two full-time and one part-time pharmacists; one full-time accuracy checking technician (ACT); two full-time and five part-time dispensers, two were weekend only; three assistant managers who were all dispensers; one full-time and two part-time medicine counter assistants, one was Sunday only. The pharmacy typically had three team members in the dispensary and one on the medicines counter. It did not always have a medicines counter assistant, so dispensers covered the counter following a rota. Team members explained this could be challenging at busy times. The pharmacy had recently been affected by staff absence, meaning the ACT had to dispense, so could not undertake as much accuracy checking as usual. Part-time team members had some scope to work flexibly providing contingency for absence. The pharmacy was busy during the inspection and staffing challenges were observed. The pharmacist requested help from an assistant manager which relieved some pressure.

One of the full-time pharmacists had started working in this pharmacy recently; previously relief pharmacists had covered these hours. The two pharmacists had four hours' overlap daily and used two hours each day to run the travel and vaccination clinic. Two pharmacists worked all day Saturday, so the clinic ran most of the day. The part-time pharmacist worked two days and three days alternate weeks. She provided day off cover, and sometimes the three pharmacists overlapped. When they did, they opened the clinic to provide more appointments. The pharmacy could often not meet demand, so these additional vaccination appointments were welcomed by the local community. The pharmacist was reviewing staffing levels and pharmacist hours with her manager, with a view to working longer hours to increase the availability of the vaccination service.

The pharmacy provided weekly protected learning time for all team members to undertake regular training and development. Team members undertook a variety of training and reading including information on services and high-risk medicines, and re-reading associated SOPs; mandatory compliance training such as safeguarding, information governance, and health and safety; patient safety reviews and the 'professional standard' which shared information and case studies across the company. The pharmacy had devised a template to record all training and reading to be completed. Team members updated this, and the ACT, pharmacists and managers monitored it. A trainer from head office visited the pharmacy monthly to provide product knowledge training and resources to the medicines counter assistant. She cascaded this to the rest of the team. The pharmacists undertook additional training for the specialist services, often attending courses in other locations. Team members had annual development meetings to identify their learning needs. The ACT and pharmacists met with

the manager, and dispensers met an assistant manager with input from pharmacists and the ACT. The company process no longer included actual reviews for dispensers, but a team member had suggested that this was a valuable tool for team development. The pharmacists and management team had agreed, and this was in the process of being set up with the new store manager. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. Examples were observed of effective questioning, and polite and professional conversations by phone, including an apology for a slight system failure in the pharmacy.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions as noted above and described feeling able to raise concerns to the pharmacists or manager. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this document and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The team seldom met together due to the extended hours and variety of work patterns. But they communicated by reading correspondence and other documents. They used a notice board to share documents and information. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters, some relating to services. Team members described how they used these as a reminder to offer services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy services provided. Although the pharmacy would benefit from a larger dispensary. The pharmacy team members use a private room for some additional services and conversations with people. Other people cannot hear these conversations. This room is often in use, meaning that other people cannot use it. So people either have to wait, or sometimes the pharmacy team members use a room in the optician's department. The pharmacy is secure when closed.

Inspector's evidence

These were large premises incorporating a large retail area, small dispensary, and back-shop area on ground and first floor levels including storage space, offices and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilets. There was a customer toilet and baby change area. These had hot and cold running water, soap, and clean hand towels. The dispensary was small for the volume of dispensing and had very limited storage spaces. The pharmacy had fridges in the back-shop area, meaning team members had to leave the dispensary to retrieve medicines from them.

People were not usually able to see activities being undertaken in the dispensary as team members managed this, asking people to stand back. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. It was very small, and the pharmacist described how she managed the occasional person who fainted during vaccination. The room was used for large periods during most days for vaccination appointments. The pharmacist also supervised opioid replacement therapy in this room, as well as a variety of other consultations. Sometimes the room was required while it was being used for another service. The pharmacist was often able to use a room within the in-store optician's department in this situation. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. It provides services such as vaccination that are popular with the local community. The pharmacy team provides safe services. Team members give people information to help them make choices and use their medicines safely. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy was open at weekends and evenings. And it had good physical access by means of a large car park, level entrance and automatic doors. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy had identified a need locally for travel and other vaccinations and this was growing. The pharmacist was currently reviewing this to increase access to these services. The pharmacy provided a complete travel service and was registered as a yellow fever centre. It offered vaccination against pneumonia, flu during the season, human papillomavirus (HPV), chickenpox and meningitis B. These were all popular with different groups of people. The pharmacist asked people having flu vaccination if they would like pneumonia vaccination. It was available to all people over 75 on the NHS, but younger people could choose to have it privately in the pharmacy.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. Team members followed a rota for different types of dispensing and working on the medicines counter at certain times of day. This ensured that all members of the team were competent to undertake dispensing of walk-in prescriptions, collection service prescriptions, assemble balances and instalment prescriptions. They used pharmacist information forms with all prescriptions to share information with the pharmacist such as new items or any changes. And they used cards to highlight high-risk medicines, those requiring special storage and when pharmacist intervention was required. The work flow was methodical with some prescriptions dispensed at the front of the dispensary in front of people. Team members took care to protect people's information. The dispensary was small and sometimes there was congestion during the dispensing process. 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, accuracy checking, clinically checking and handing out. The accuracy checking technician (ACT) carried out the accuracy check of dispensed items that had been clinically checked by a pharmacist who had initialled the prescriptions. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. The team was trying to reduce the number of owings by reviewing medicines involved and managing the stock.

A few people received medicines from chronic medication service (CMS) serial prescriptions. Team members had no concerns about compliance or concordance with these prescriptions. The pharmacy was sometimes registering people for this service, informed by number of people registered against target. A pharmacist had a conversation with the person using an initial consultation form which had been devised in the pharmacy. She asked general questions such as how the person was getting on with

their medicines, if they thought they were effective, and did they think they had any side effects. She then used more targeted questions depending on the medicines the person was taking. Sometimes the pharmacist identified pharmaceutical care issues using this technique. And she had conversations with all people about their medicines. She described an example the previous day when a person on a blood pressure lowering medicine described feeling lightheaded. The pharmacist measured her blood pressure and found it to be at the low end of normal so referred her to her doctor for review of her medication. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members followed a SOP, provided patient information leaflets with the first pack of each prescription and included tablet descriptions on labels. They kept thorough records of medicine changes or other interventions. They were not taking on new people for this service currently as there was inadequate space to manage and store these. They signposted people to the closest branch that had capacity. Team members had all read a new SOP so could describe assessments that would now be undertaken for any new people starting the service.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and confirmed that it did not supply valproate to anyone in this group. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also followed private PGDs for vaccinations and hair retention treatment. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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.

A large part of the pharmacy's work was service delivery, mainly vaccination. The team managed appointments using an online system and planned them for times when there were two pharmacists working. The pharmacy had arranged for an additional pharmacist for the following week when flu vaccination was starting. Its diary was full. The three regular pharmacists were fully trained in all aspects of the vaccinations. Except, one pharmacist was not yet fully trained to administer chicken pox vaccine. It was administered differently to the others. He was booked on additional training over coming weeks. The pharmacists initially undertook online disease specific training. Then they had face to face training every two years, and annual online training, to ensure their vaccination technique was correct and they were competent to deal with anaphylaxis. They also had additional chicken-pox and travel training. The pharmacy kept records of this training. The pharmacy kept thorough patient records which were methodically filed for the different vaccinations. People provided medical and vaccination history which the pharmacist recorded. She then followed a checklist to ensure she had all the information she required. She discussed allergies and asked about previous reactions to vaccination. The pharmacy used the 'Travel Pro' website which was a credible and up-to-date travel site. The person's record was populated with recommendations automatically, and the pharmacist showed this to the person. Some people required follow-up appointments for booster vaccinations. These were shorter appointments and booked with the pharmacist. The vaccines were stored in a fridge in the back-shop area. When the pharmacist selected these, she asked another team member to check it was

the correct item. Both also checked the expiry date of the vaccine and the emergency adrenaline. They recorded the expiry dates and batch numbers, and both signed the person's record. The pharmacist placed the vaccines into a basket containing all sundries and took this to the consultation room. She cleaned her hands in front of people just prior to vaccination. The pharmacist told people that she had adrenaline and could quickly respond to a serious reaction. She described how she dealt with fainting as the consultation room was small. She raised people's feet whilst in a sitting position as soon as possible. This did not happen often. She asked people to remain in the pharmacy for five or ten minutes after vaccination to ensure they felt well before leaving. A pharmacist measured blood pressure on request or if there was a clinical need. All pharmacists were trained and competent to supply hair retention medication following a PGD. The part-time pharmacist was mainly delivering this service currently.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). Team members had not undertaken training and most had not heard of this requirement. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in three fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Two fridges were in the back-shop area with one used for dispensed medicines, and the other for vaccines. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy kept records of date checking, which took place every three months, for a few years. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. 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 for the delivery of its services. It looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. And it had equipment and sundries to use during loss of power or internet (offline crash packs).

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, a blood pressure meter which was replaced as per the manufacturer's guidance and infection control items including gloves, sharps receptacles, alcohol hand cleanser and Hibiscrub. The pharmacists kept a basket in the dispensary containing all the sundries required for vaccination, and resuscitation equipment including emergency adrenaline. They added relevant vaccines prior to administration and took the basket to the consultation room. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and these were cleaned after use. As methotrexate tablets were supplied in blister packaging there was no longer a separate counter kept for these.

The pharmacy stored paper records in files in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left 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.