General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 28-30 Newington Road, EDINBURGH, Midlothian, EH9 1QS

Pharmacy reference: 1042722

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

This is a community pharmacy on a main road near the city centre close to other non-retail businesses. It dispenses NHS prescriptions including supplying medicines in multi-compartmental compliance packs. The pharmacy offers a repeat prescription collection service. And charged-for medicines' delivery service. It also provides substance misuse services. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines. It offers smoking cessation, seasonal flu vaccination and malaria prophylaxis.

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 records and reviews errors to learn from them. And it keeps records of improvements made. The pharmacist checks that team members understand and are following written processes.
		1.4	Good practice	The pharmacy encourages feedback from people. And it uses this feedback to build-on and improve services.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides time and material for team members to develop and improve their skills. And it supports new and inexperienced team members to ensure they are providing safe services.
		2.3	Good practice	Team members have discussions with people to identify ways to help them. And they demonstrate positive outcomes for people.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team manages work load well to provide an efficient medicines' supply service. And team members identify the needs of people and address them appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. And pharmacy team members discuss this to make pharmacy services better. 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. Team members signed the SOPs as they read and understood them. The pharmacist tested team members' understanding and signed them off when they were competent in tasks. 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. The pharmacy technician had additional responsibilities including running the dispensary and sometimes undertaking controlled drug running balance audits. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had emergency contact numbers listed on the dispensary wall for ease of access including head office emergency contacts and who to contact in the event of a major incident.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. A team member had identified situations when she made counting and arithmetical mistakes. She had discussed this with the pharmacist and now used a calculator even for simple calculations, which had greatly improved her accuracy. The pharmacy technician undertook patient safety reviews monthly or following an error. The team discussed this each month and made changes and introduced strategies to improve accuracy. The pharmacist had reminded all team members to always doublecheck their dispensing before passing for its final accuracy check. She had also reminded them to keep dispensing benches clear and tidy. The most common error identified was incorrect quantities, with wrong medicine very seldom identified. Team members had separated some items on shelves and used warning labels to highlight these. Examples were bisoprolol and bendroflumethiazide; and simvastatin and atorvastatin. They kept a list of similar looking and sounding items on the labeller for reference. Head office had provided this and team members added their own examples. They had discussed an incident resulting in a complaint related to a clinical decision. And they had reflected on how the incident could have been handled better.

The pharmacy had a complaints procedure and welcomed feedback. People used an online form to feedback to the pharmacy. They made positive comments about the flu vaccination service, and the help and advice they received about prescription and over-the-counter medicines. People explained that they made a special trip to this pharmacy for flu vaccination as they liked the continuity of the same pharmacist having provided the service for three years. (This was observed during the inspection.) The pharmacy team was building on this feedback by ensuring that team members continued to

provide the same high standard of service. They shared feedback among themselves to learn from it and improve services. A recent example was learning from a customer that Scottish £1 notes could legally be accepted. This followed a complaint made to head office. And team members always ensured that they did what they said they were going to do e.g. phoning people back in a timely manner.

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; 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.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertaken annual training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. The pharmacy displayed a fair data processing notice. Team members had also read a SOP and undertaken training annual on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; 1 full-time pharmacy technician; one part-time (28.5 hours per week) pharmacy advisor (dispenser and medicines counter trained); one part-time trainee pharmacy advisor from another branch, who was covering following a team member moving branch; and two recently employed trainee pharmacy advisors working eight hours on Fridays and Saturdays. The pharmacy was recruiting for a qualified part-time pharmacy advisor to replace the one who had left. The pharmacist explained she would prefer not to have any more untrained team members as this could impact pharmacy services and her time. The pharmacy used delivery drivers from a central hub. The pharmacy displayed team members' certificates of qualification. Typically, there were two team members and the pharmacist working at most times. Usually one team member was in the back-shop area assembling multi-compartmental compliance packs. One day per week there were three team members for part of the day. The team used this time to undertake some retail and administration tasks. Team members were able to manage the workload. The pharmacy had reviewed staffing levels recently when the team member had moved to another branch. And it had decided to recruit as described.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. Head office provided regular training resources. The pharmacy provided team members undertaking accredited courses with additional time to complete coursework. The trainee pharmacy adviser had completed coursework and was now undertaking on-the-job coaching with new tasks. The pharmacist was giving her feedback and encouragement. A very new trainee pharmacy adviser working eight hours per week was supervised by the pharmacist and was being introduced to the 'healthcare way'. She had one hour per week 'off-the-job' training time to read introductory training material including SOPs. The pharmacist did not sign off SOPs until team members were observed to be fully competent. The pharmacy displayed the timeline for GPhC registration revalidation on the dispensary wall as a reference for the pharmacist and pharmacy technician. They had both recently completed their revalidation tasks. Team members had annual development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included completing accredited training and promoting services to people who would benefit from them. 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. All team members were very professional and friendly when speaking to people. And they

communicated effectively giving quality advice. Team members asked relevant questions to ascertain facts before referring issues to the pharmacist. The pharmacist checked with people that they knew how to take their medicines and advised accordingly. She asked people if they required repeat medicines that she did not have a prescription for. She sometimes identified that prescriptions were required and contacted the GP practice to obtain these. This ensured that people did not go without necessary medicines. During the inspection an example was observed of prescriptions being printed at the GP practice but not supplied to the pharmacy. The pharmacist arranged with the GP practice that prescriptions would be reprinted, and she provided medication in advance. This issue would not have been identified if the pharmacist did not engage with people at this level. Team members explained that this type of conversation was normal; they always chatted to people to get to know them and they tried to accommodate people in any way that they could.

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 and raise concerns to the manager or area manager. Team members described discussions leading to changes in the pharmacy to improve services. They could all make suggestions and their contributions were valued. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read the 'Professional standard' document which included case studies and other topics for learning. The pharmacy team had put labels on shelves to highlight high-risk items following shared learning, including diabetic medicines, methotrexate and quetiapine. Team members described discussing the case studies; a recent one was about an item missing from a person's bag. The pharmacist had highlighted points for discussion and this was observed. Team members signed the document as they read and discussed it. The team had meetings to discuss incidents and discussed them on-the-job. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described how they used these to remind them 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's services. The pharmacy deals appropriately with maintenance issues. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations.

Inspector's evidence

These were small premises incorporating a retail area, dispensary, small back-shop area and large basement. The team used the back-shop room for the management of multi-compartmental compliance packs. The basement was damp in areas, but the pharmacy did not store medicines there. The basement was segregated into several sections and the exit and fire exit, were well-marked. The staff facilities were in a dry part of the basement. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The premises were clean and hygienic. The team was aware of an area where there was asbestos which had been addressed and did not pose a risk. Team members told visitors to ensure this area was not disturbed. A pest control company visited and inspected the premises monthly. It was monitoring previous infestations with ants and mice. The pharmacy had traps but there was no evidence of current infestation. The pharmacy was on the ground floor of a tenement building. The building had had scaffolding up for a few years to address external maintenance in other parts of the building.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The pharmacy also had a separate discreet area beside the medicines counter. The team used this for quiet conversations and for specialist services such as substance misuse supervision. Temperature and lighting were comfortable. The pharmacy had put in additional heaters to be used in the winter when the premises were cold.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members all play their part in different services to ensure that the are safe and effective. They give people information to help them use their medicines. And 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 had good physical access by means of a low step and an automatic door. It had a doorbell for people to use if they required help. It listed its services and had leaflets available on a variety of topics including the valproate pregnancy prevention programme. The pharmacy signposted people to other services such as human papillomavirus (hpv) vaccination. 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 provided a delivery service and people signed to acknowledge receipt of their medicines. The delivery van had a monitored cool-box for items requiring cold storage. And it had a locked receptacle for controlled drugs. The pharmacy team logged items for delivery electronically, so the driver knew if there were any items requiring special storage.

Pharmacy team members followed a logical and methodical workflow for dispensing. Most of the pharmacy's dispensing workload was from managed repeat prescriptions. So team members could plan how the workload was managed. They used baskets to differentiate between different prescription types and separate people's medicines and prescriptions. They had arranged the workflow in a smooth and logical manner to ensure safety and effectiveness. They prioritised 'walk- in' prescriptions which were labelled and dispensed at the front of the dispensary. Team members used pharmacist information forms (PIFs) to share information with the pharmacist for every prescription. They also used labels to identify controlled drugs, items needing cold storage and pharmacist intervention. The pharmacy technician often asked other team members what the PIF had written on it to ensure that they were all using it and reading it. They used these forms to record a variety of information including dates of previous medicine supply and outcomes of conversations with the GP practice. They always recorded the date of the previous supply if it was not as expected or if there was any doubt. The pharmacy ordered managed repeat prescriptions a week before they were required. And they told people to call for their medicines in afternoons as prescriptions arrived in the pharmacy late morning. Team members arranged prescriptions in date order when they arrived in the pharmacy to ensure that medicines were always ready for people as they expected them. The pharmacy sent texts to people to notify them when their medicines were ready. But the pharmacist explained that she also told people to contact the pharmacy if they had not had notification as expected. This did not happen often, but the pharmacist was aware that occasionally texts were not received. She always told people to contact the pharmacy if they were running out of medicine and reassured them that they would never be left short. Some dispensed medicines were observed on retrieval shelves from several weeks before. Team members explained that letters had been sent to remind people to collect their medicines. And they knew most people so could provide plausible reasons for medicines which had not been collected yet. A team member explained that most people came to the pharmacy following receipt of their letter and had not been without medicines. 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 and handing out. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. A few people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these a week before and had not identified any issues with compliance. The pharmacy was actively registering people for this service although most eligible people had already been invited to register. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. The dispenser usually undertook this task, but the pharmacy technician was competent to deputise. Team members ordered prescriptions when there were two weeks' medicine supply left. This gave adequate time to address any queries and assemble packs before they were needed. The pharmacy team managed all aspects of multi-compartmental compliance packs in a back-shop room where they were assembled, checked and stored. The team stored packs in clear bags in individual labelled boxes for each person. This enabled team members to read the patient details and date of supply on the pack which helped the delivery driver. The pharmacy provided four packs at a time to a few people to suit the individual family situations. This was mainly to enable family members to collect the medicines monthly following the company's introduction of a delivery charge. The pharmacy had contacted prescribers to authorise this and it was recorded on patient medication records. But there was nothing in writing from prescribers. The pharmacy had a list on the wall of packs to be supplied each day.

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 and had some leaflets available on the shop floor. It had undertaken a search for people in the 'at-risk' group and did not supply valproate to anyone in this group. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and team members gave written and verbal information 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. GPs often included this information on prescriptions for labelling, but pharmacy team members still provided counselling. 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 flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence, under the pharmacist's supervision. The pharmacy technician explained the process for this service to locum and relief pharmacists when they started work in the morning. This ensured that they were aware of the usual process and were satisfied that it was appropriate. The regular pharmacist explained that when trainee team members were involved in delivering the service she always asked them what action they thought was appropriate and she coached them. All team members 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.

Flu vaccination service was currently a large part of the workload. The pharmacist was very experienced and had delivered the service for three years in the pharmacy. As noted elsewhere, many people returned because they had had a satisfactory experience in previous years. There were currently shortages with vaccines, so the pharmacist was managing this carefully and not booking appointments for the following week. The pharmacy was part of an NHS pilot delivering vaccination to people who met certain criteria. But the pharmacist had not vaccinated many people in this category yet. A lot of people from local businesses used the service and corporate arrangements for payment were in place.

The pharmacy promoted the service locally. The pharmacist had undertaken face-to-face training the previous year and an online refresher course this year. She described the process and much of this was observed during the inspection. Following the actual vaccination, she chatted to people to ensure that they were well and encouraged them to walk slowly to the door and wait in the pharmacy if they felt unwell. Team members were familiar with the paperwork to be completed before and after the vaccination. And they did much of this to share the workload with the pharmacist. The pharmacy technician oversaw this and ensured that there was no backup of paperwork. She was keen to be more involved with the service. And she had discussed it with the area to ensure that she would be enrolled on training if it was ever available for pharmacy technicians. During the inspection a person presented at the pharmacy without an appointment and explained that he had previously had his vaccination in this pharmacy and would like to do so again – he was not from the immediate area. The pharmacy technician confirmed with the pharmacist that she could accommodate this. Then the pharmacy technician asked the person to complete the required form and she selected the correct vaccine and recorded information such as batch number and expiry date on the form before giving it to the pharmacist to check and undertake the vaccination. This provided a professional, efficient and quick service that the person being vaccinated appreciated. He was eligible for NHS vaccination and the pharmacy technician explained this to him at the outset. However, his preference was to have it done privately in the pharmacy. The pharmacist delivered the smoking cessation service and much of it was now shared care with nurses. The pharmacist was mainly involved with supplying nicotine replacement therapy after confirming that the nurses had suggested the most appropriate product. Nurses undertook carbon monoxide monitoring with people.

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). The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. It stored flammable liquids including acetone in a labelled ‘flammable cupboard’. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. 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. The pharmacy 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.

The pharmacy kept a carbon monoxide monitor maintained by the health board in the consultation room. And it had sundries required for vaccination and a first aid kit. The outside of the first aid box was dirty but it was clean and hygienic inside. The pharmacist kept an anaphylaxis kit in the dispensary. She took it to the consultation room for vaccination appointments. 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 kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and the back-shop areas 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.