General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 49-51 Albert Square, Kirkwall, ORKNEY, Orkney & Shetland, KW15 1HQ

Pharmacy reference: 1042800

Type of pharmacy: Community

Date of inspection: 24/05/2024

Pharmacy context

This is a community pharmacy in Kirkwall. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

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 team members work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined the pharmacy's working practices in a range of relevant standard operating procedures (SOPs). Electronic versions were readily available for team members to access whenever they needed to. This included new and updated SOPs that the superintendent's office (SI) regularly issued every month. Team members read the new SOPs within the necessary timescales, and they completed a test to confirm their understanding. The pharmacist monitored ongoing compliance with SOPs and provided extra support when improvement was needed.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. The pharmacist was able to identify and help team members learn from their dispensing mistakes. This included recording and monitoring errors identified before they reached people, known as near miss errors. They discussed these errors with the pharmacy team to identify any patterns and trends and agree actions to manage dispensing risks. They documented the agreed improvements on a monthly patient safety review which they displayed in a prominent position on the dispensary wall for all team members to see. The pharmacy had introduced bar-code scanning technology to identify errors, such as selecting the wrong medication or one that had already expired. The number and the category of errors had fallen since its introduction and team members had identified incorrect quantities as the most common error. This meant they knew to take more care when counting the number of prescribed doses. The pharmacy dispensed a considerable number of prescriptions that were hand-written by nurse prescribers. These prescriptions did not include a bar code and team members knew to take extra care and to obtain an extra check prior to the pharmacist's final accuracy check to manage the risk of dispensing mistakes. The pharmacist conducted checks to ensure that the pharmacy's clinical governance arrangements were up to date and an area manager conducted random checks to provide extra assurance.

Team members knew how to manage complaints and knew to escalate dispensing mistakes that people reported after they left the pharmacy. The pharmacist knew to conduct a formal investigation and to complete an incident report if necessary. This included recording information about the root cause and any improvements they had made. They discussed the incidents with team members, so they learned how to manage risks to keep dispensing safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area and the RP record was up to date. Team members maintained controlled drug (CD) registers and they checked and verified the balances once a week. The pharmacy kept records of CDs that people returned for disposal and a signature audit trail provided assurance that destructions had taken place. Team members filed prescriptions so they could easily

retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date.

The pharmacy protected people's privacy and they used an approved provider to safely collect confidential waste for off-site destruction. The pharmacy trained its team members to identify vulnerable adults and children and they knew to discuss safeguarding concerns with the pharmacist to protect them. For example, when some people did not collect their medication on time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The pharmacy regularly reviewed its staffing levels and skill mix arrangements and made improvements when there were shortfalls. Following feedback from the regular pharmacist the pharmacy only employed locum pharmacists that were eligible to make supplies using patient group directions (PGDs). This ensured team members had the necessary competencies to provide the pharmacy's services most of the time. The pharmacy had recently recruited two part-time trainee dispensers in December 2023 to replace a full-time dispenser to better suit the pharmacy's service arrangements. The following team members were in post; a regular full-time pharmacist, one full-time second pharmacist, three full-time dispensers, two part-time trainee dispensers and four part-time medicines counter assistants. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one time. A pharmacy student worked over the summer months and provided cover for the other team members when they were on annual leave.

The pharmacy had a 12-week induction programme for new team members. They were required to read the relevant pharmacy SOPs, complete e-learning such as health and safety, data protection and safeguarding vulnerable people modules. The pharmacy enrolled new team members onto qualification training and the pharmacist provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress. The pharmacist maintained a roles and responsibilities matrix that showed the competencies of each team member. They also used the matrix to identify training needs and organise development activities. The company encouraged and supported experienced team members to enrol on qualification training. This included pharmacy technician and pharmacist independent prescribing training.

The pharmacist ensured team members kept up to date in their roles and responsibilities. They discussed the monthly patient safety review to identify and implement safety improvements. They also discussed the company's monthly newsletter which included learnings from significant incidents that had occurred in other branches. Team members had recently learned about a new operating procedure and knew to scan prescription bag labels. This ensured they didn't miss items such as those requiring refrigeration. Team members provided other sources of learning such as medication shortages and when to make alternative supplies that had already been authorised by prescribers. The pharmacy trained team members so they understood their obligations to raise whistleblowing concerns and a copy of the policy was displayed in the dispensary. This ensured they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in a modern purpose-built premises. Team members managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations in the main dispensary depending on the various tasks they conducted. This included a separate area for final accuracy checks. A rear dispensary was mostly used to assemble and label prescriptions for a care home. This ensured there was sufficient space for the prescriptions and the relevant documentation to keep dispensing safe.

The pharmacist had good visibility of the medicines counter and could intervene when necessary. The pharmacy had a separate dedicated well-equipped consultation room with hot and cold running water. It provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy provided access via a level entrance which helped people with mobility difficulties. A range of patient information leaflets helped people understand health conditions and available treatments. The pharmacy had an arrangement with the local medical practice and the regular pharmacist provided an out-of-hours dispensing service. This ensured people had access to medicines when they urgently needed them. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. These included checks of expiry dates which they documented to show when checks were next due. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated which helped team members manage the risk of selection errors. They used clear bags for items they had previously dispensed and awaited collection. This made retrieval easier and helped with the necessary safety checks that were required before making a supply. Team members used secure cabinets for some of its items and medicines were organised with segregated items awaiting destruction.

The pharmacy received drug alerts and recall notifications. Team members checked the notifications and acted on them when necessary. They kept audit trails to confirm they had conducted the necessary checks which included removing affected items and isolating them from stock. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy sent a considerable number of prescriptions to an off-site hub for dispensing. This had been effective at helping team members manage the pharmacy’s dispensing workload and provide service continuity when there had been a high turnover of staff. They made sure they sent prescriptions well in advance due to the pharmacy’s remote location. But sometimes it was necessary to dispense urgent prescriptions on-site due to ferry disruptions and medication delays. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. A local care home sent monthly prescriptions to the pharmacy for dispensing. Team members used a separate rear room to assemble the prescriptions which helped to keep dispensing safe and effective. The pharmacist authorised only experienced team members to dispense care home prescriptions. This helped new team members to safely develop the necessary knowledge and skills and ensured compliance with the relevant pharmacy

SOPs. The pharmacy delivered prescriptions to medical practices on the other Orkney islands for people to collect. They placed items in a tote which they sealed with a numbered tag. They recorded the relevant information on a form, so they had an audit trail of individual prescriptions. Team members at the medical practices checked that the seal was intact, and they signed and returned the form to the pharmacy to provide confirmation they had been received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets.

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.