General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 49 Allen Street, BLAIRGOWRIE, Perthshire, PH10 6AB

Pharmacy reference: 1042809

Type of pharmacy: Community

Date of inspection: 19/08/2019

Pharmacy context

This is a community pharmacy on a high street in a small town. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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 regularly and comprehensively reviews patient safety incidents. It links these to incidents occurring elsewhere for increased learning. The team puts strategies in place to improve patient safety.
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 follow processes for all services to ensure that they are safe. The pharmacy reviews these and makes changes to keep improving services. And it plans for new services to ensure they are introduced safely. The pharmacy team records mistakes to learn from them. It reviews these and makes changes to avoid the same mistake happening again. Team members discuss these mistakes and compare them with incidents elsewhere for greater learning. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect the welfare of 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. They were working through SOPs which had been received recently including one for high-risk medicines for e.g. lithium, methotrexate, warfarin, other anticoagulants and insulin. 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 managed dispensing, a high-risk activity, well, with baskets used to separate people's medication. The pharmacy is considering introducing flu vaccination over coming months and as described below the pharmacist is planning for this and identifying and managing associated risks. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It displayed a lot of information and phone numbers on the wall of the dispensary to enable team members to deal quickly with different situations. These included the number to call if a pharmacist did not turn up, and numbers for suppliers, hospitals, other healthcare professionals, other pharmacies and the out-of-hours medical service.

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. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. The dispenser undertaking a recent review had highlighted that there had been a handout error, and this was also the topic of a case study from the pharmacy superintendent. All team members had re-read the SOP regarding handing out medicines and watched a short training video. They were now following a revised process that divided handing out into two distinct phases to avoid this happening in the future. A colourful version of the SOP was on the dispensary wall beside the safer care reviews. The pharmacy had recently introduced material to draw attention to medicines that were similar sounding or similar looking that were often implicated in mistakes. Team members had placed this material in various places in the dispensary as a reminder. They initialled prescriptions for these items as they dispensed them to signify that they had double checked. The pharmacy included gabapentin and pregabalin in this list of medicines as they were often incorrectly interchanged.

The pharmacy had a complaints procedure and welcomed feedback. The pharmacy had an indemnity insurance certificate, expiring 31 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 undertook annual training using e-learning modules. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP and undertook annual training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. Tayside child protection information was displayed in the dispensary. Team members explained that they were often asked where this information was to ensure that they would be able to raise a concern in a hurry if they had to. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services although sometimes it is short-staffed. The team members have access to training material to ensure that they have the skills they need. They do this in their own time. Team members can share information and raise concerns to keep the pharmacy safe. They discuss incidents that occur in the pharmacy and in the wider organisation. They learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist, one full-time manager who was also a dispenser, three part-time pharmacy advisors (dispensary and medicines counter assistants), one Saturday only pharmacy advisor and a delivery driver. At the time of inspection the pharmacy was staffed with the regular pharmacist, the manager and one pharmacy advisor. This was typical of Mondays, Fridays and Saturdays. The pharmacy usually had four team members including a pharmacist on other days. The team was managing the workload, but under significant pressure during the inspection, with periods of time when all team members were speaking to people, so no one was able to dispense. The inspection was carried out on a Monday, and the prescriptions that had been collected from the surgery on the Friday had not yet been labelled. Team members were dealing very professionally and calmly with the situation but were not able to be proactive. They were reacting to requests from people i.e. dispensing prescriptions as people presented at the pharmacy because they had not been done previously. As team members were all constantly busy, it was sometimes difficult to speak to them to gather evidence during the inspection. The manager was halfway through a six-month secondment to this pharmacy. She was an inexperienced dispenser and was therefore still learning. She was undertaking management tasks during her lunch breaks. The previous incumbent was a more experienced dispenser, and this change was contributing to the pressure in the pharmacy. The pharmacy was recruiting for a Saturday only team member following a recent resignation. In the meantime, other team members were taking it in turn to work Saturdays and have a day off during the week. This contributed to shortages at some points during the week. Part-time team members had some scope to work flexibly providing contingency for absence. The pharmacy team was managing to undertake all routine tasks such as date checking and controlled drug running balance audits. Team members were organising their time well and keeping the pharmacy tidy to help the smooth running of the pharmacy.

The pharmacy could not provide protected learning time for team members to undertake regular training and development. All team members were up-to-date with mandatory reading and learning including SOPs, e-learning modules and reading other company documentation including the ‘professional standard’. They read this material and undertook training during their lunch breaks. The various individuals were observed going about their tasks in a systematic and professional manner. All team members demonstrated a very friendly, calm and professional demeanour. 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.

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. 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, the 'professional standard' and associated papers and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. Recently the dispenser who undertook safer care reviews had linked an incident in the pharmacy with a case study, which the team had found beneficial. The team had occasional team meetings, although most information was shared and discussed 'on the job'. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters including services. Team members explained that they offered services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. The pharmacy is secure when closed. Pharmacy team members raise concerns when there is damage to the premises. But this is not always addressed quickly.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, dispensary and back shop area including storage and staff facilities. The premises were clean, hygienic and mostly well maintained. The pharmacy team had reported a broken shutter at a large front window several weeks previously, and again last week. The broken shutter was permanently in a closed position, giving an impression that the pharmacy was closed. Most local people were aware that the pharmacy was open as usual despite the closed shutter. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. The pharmacy had a consultation room with a desk and chairs. It was also used as they pharmacy office and electronic devices related to point-of-sale equipment were kept here. They could be screened off when the room was used as a consultation room. The door closed providing privacy. The pharmacy had a hatch through to the dispensary in a discreet area towards the rear of the retail area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy identifies additional services that the community would benefit from and plans for these. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. 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 directions with dispensed medicines. 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.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to differentiate between different people's medicines and prescriptions. Dispensers used pharmacist information forms (PIFs) to share information with the pharmacist. They used these with all prescriptions which enabled the pharmacist to undertake clinical assessments. 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. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these a few days before the expected supply date. It filed them in date order to facilitate this. A team member checked the retrieval shelves regularly and items were removed after a month, meaning that people could be without medicines for a few weeks. The pharmacist explained that there was no evidence of this happening for people with CMS serial prescriptions. The pharmacy was actively registering people for this service. All team members were involved with this. One dispenser described how she avoided asking specific closed questions but had a general conversation with people about their medicines. She explained that this resulted in a lot of information which addressed the questions on the template and gave additional information. She recorded all of this and shared with the pharmacist. The pharmacist identified some pharmaceutical care issues including side-effects. She advised people as appropriate and referred to the GP when necessary. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members usually did this on Saturdays when there was more time. They ordered prescriptions and sometimes started labelling during the week. Recently this had not been possible as staffing levels had been tight. They were currently working less than one week ahead, and until recently they had been two weeks ahead. The pharmacist explained that although this process was not being carried out as far in advance as previously, she had adequate time to check medicines and was not concerned. She explained that the situation should improve and would certainly not get worse. Team members followed the SOP which was a robust process and thorough and complete records were maintained. They monitored progress of each prescription to ensure that all were managed in a timely manner. Team members included date of supply and instalment number on each pack and tablet descriptions were on labels. They supplied patient information leaflets (PILs) monthly. The pharmacy stored completed packs in individual labelled boxes on dedicated shelves in the

back-shop area. It followed a robust process for supplying large numbers of tablets in more than one pack per week, ensuring that people were supplied with the correct packs. The pharmacy supplied a variety of other medicines by instalment. A team member assembled all instalments and placed each into an individual bag which was labelled with patient details and date of supply. They were stored on dedicated shelves in named boxes.

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 the pharmacist had counselled them appropriately. 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, and the supply of chloramphenicol ophthalmic products. 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. Team members described examples of how they managed the minor ailments service and what they referred to the pharmacist. These were appropriate.

The pharmacist managed the smoking cessation service and there were currently around three people accessing it. She could describe some recent successes. The pharmacy was planning to deliver flu vaccination during the coming season. The pharmacist had previously been trained so was competent to undertake this. She described how she was going to promote and manage the service. She believed that people would want the vaccination during their lunch times, so she was considering how to manage the pharmacy team lunches to accommodate this. She was also considering timing and how many people she could see each day.

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). Members were aware of this legislation and the new security aspects of some medicines packaging. But there was no equipment in the pharmacy to deliver this and there had been no training. 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. 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 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 had equipment it required to deliver pharmacy services. This included a carbon monoxide monitor maintained by the health board, clean tablet and capsule counters, crown stamped measures with separate marked ones for methadone, and a pump for methadone use. A team member cleaned the pump after each use and poured test volumes each time the volume was changed. The pharmacy sent the pump for annual calibration.

The pharmacy stored paper records in the dispensary and back-shop areas inaccessible to the public. Team members used passwords to access computers and never left them unattended unless they were locked. Team members carefully placed bags of dispensed medicines with the private information facing away from the public as they were stored on shelves behind the medicines counter where they could be seen.

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.