General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 97-99 High Street, INVERGORDON, Ross-Shire, IV18 0AB

Pharmacy reference: 1042854

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

This is a community pharmacy on the High Street in Invergordon. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It also provides dispensing for care homes. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers a smoking cessation service and seasonal flu vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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	Good practice	1.2	Good practice	The pharmacy embeds continuous improvement in its culture. The pharmacy team ensures it learns when things go wrong. And it takes its time to discuss and identify risks so that the safety and effectiveness of its services continue to improve.
		1.7	Good practice	The pharmacy has a systematic approach to information governance. It provides regular training. And it carries out regular reviews to confirm that its arrangements meet data protection requirements.
		1.8	Good practice	There is a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults.
2. Staff	Good practice	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
		2.4	Good practice	The pharmacy team members work effectively. And they are comfortable talking about their weaknesses and the importance of shared learning. They focus on continuous improvement. And they want to provide good outcomes for people.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Good practice	4.2	Good practice	The pharmacy team manages its services to ensure they optimise efficiency and effectiveness. And it ensures its services provide good outcomes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team members work to professional standards. They provide safe services and look after people's welfare. The pharmacy keeps records of mistakes when they happen. And the team members are proactive at identifying risks and carrying out service improvements. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means that they listen to people and put things right when they can. The pharmacy encourages people to provide feedback about its services. And they make changes to their processes when they need to.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The company had updated and issued new dispensing SOPs earlier in the year. And in July 2019, each of the team members had completed an assessment to test their understanding. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The dispensers recorded their own near-misses. And the pharmacy team discussed ways of managing dispensing risks. The pharmacy produced near-miss reports. And a sample for September 2019 showed a good level of reporting with the following improvement actions;

1. Avoid multi-tasking, finishing one task before carrying out another. And re-start a process from the beginning when a task has to be abandoned.

2. Re-read the controlled drug dispensing procedure. And ensure accuracy checks are carried out before passing to the pharmacist or the ACT for a final check.

The pharmacy team used the company's list of LASA medication to manage dispensing risks. And they kept the list beside the PMR and used shelf-edge caution labels to highlight LASA stock, such as propranolol. The team members recorded LASAs on pharmacist information forms (PIFs). And they attached PIFs to prescriptions at the time they processed them on the PMR. A sample LASA showed that someone had been prescribed propranolol and two new medicines. The team members were proactive at managing risks. And the pharmacist was liaising with the surgery due to changes in the time the GPs issued acute prescriptions. The pharmacist had highlighted that the new process was creating extra pressure. And was due to people arriving with their prescriptions much later in the day. The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about an error when a locum pharmacist had supplied the wrong formulation. The investigation showed that the prescription had been hand-written. And the pharmacy team had agreed to seek further checks when prescriptions

appeared ambiguous.

The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used a practice leaflet to inform people about the complaints process. The team members had received feedback from someone with instalment prescriptions. And they reported feeling uncomfortable about having to say they were there to collect an instalment. The team members had reflected on the feedback. And they had changed the way they stored the prescriptions for collection. This avoided people having to describe the type of prescription it was and protected their dignity.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid and up to date. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for their medication to confirm receipt. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions to improve access to medicines and advice. And a sample trimethoprim patient group direction was valid until October 2020.

The pharmacy displayed a ‘fair data processing notice’ which provided people with information about its data protection arrangements. The pharmacy trained team members on a regular basis to comply with data protection arrangements. And they knew how to safeguard personal information. The pharmacy disposed of confidential information in designated bags. And it archived spent records for the standard retention period.

The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. And the company had registered the pharmacists with the scheme. The pharmacy trained the team members to comply with safeguarding arrangements. And it provided contact details so that they knew who to contact if they had a concern about a child or an adult. The team members recognised the signs and symptoms of abuse and neglect. And knew when to refer to the pharmacist. For example, they carried out checks at the end of the day. And noted when people had not collected their multi-compartmental compliance packs and instalment prescriptions. This ensured they contacted carers and the surgery so that people received extra support if they needed it.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced a slight growth in the number of NHS prescriptions it dispensed over the past year. Most of the team members had worked at the pharmacy for years. And they were experienced and knowledgeable in their roles. The pharmacy team had remained at the same level. But the pharmacy had recruited two new team members to replace people who had left. A new non-pharmacist manager had been appointed around a year ago. And she was about to complete the NVQ pharmacy services level 3 training to be eligible to register as a pharmacy technician. The pharmacy kept the team's qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time accuracy checking technician (ACT), one full-time trainee pharmacy technician (manager) and seven part-time dispensers.

The pharmacy had been operating without a regular pharmacist for a year and a half. But, a new pharmacist had been recruited in March 2019. The pharmacy team had worked with a significant number of locum pharmacists during this time, including pharmacists that had only worked in NHS England. This had presented a challenge due to the contractual differences between Scotland and England. But, the ACT had developed an induction pack that she used to provide support and assurance that locums had been informed. The ACT checked the accreditation status of locum pharmacists. And informed the surgery when they were unable to provide the pharmacy first service. The ACT was working extra at the time of the inspection. And this was due to an unplanned absence which had taken the team below the minimum safe levels due to someone who was already on leave. The pharmacy was allocated an over-time budget. And team members were willing to work extra to provide support. Two relief dispensers covered the NHS Highland area. And one of the reliefs had recently provided cover.

The manager carried out performance reviews and helped team members to identify areas for improvement. For example, the accuracy checking technician (ACT), had agreed to reflect and develop her communication skills to enable her to tailor her communication depending on the audience. For example, practice pharmacists, colleagues and telling people about the CMS service. The ACT had produced a reflective account about her communication. And used it to demonstrate compliance with GPhC revalidation requirements.

The company provided a range of training resources. And the team members were up-to-date with mandatory training requirements. For example, they had recently completed a module which promoted good patient care. The ACT and the store manager had recently attended an annual off-site training event. And there had been a focus on distractions in the work-place and how to manage them. The

team members had shared the learning in the work-place. And the pharmacist had authorised team members to close the door between the main dispensary and the room that was used to dispense multi-compartmental compliance packs to reduce distractions. The team members had agreed to let the phone ring out if they were in the middle of key tasks to safeguard patient safety.

The pharmacy supported people to learn. And the manager routinely scheduled protected learning time every week and this was recorded on the team rota. The team members used a monthly professional standards publication to learn about risks and how to avoid them. And they had recently discussed the risks associated with dispensing medicines for children. For example, when calculating dosages.

The pharmacy used performance targets. And team members were currently focussed on identifying people that would benefit from the chronic medication service (CMS). The team members did not feel undue pressure to increase services. And knew only to recommend services that would be beneficial to individuals. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, the pharmacist had raised the issue of unobtainable stock. And had suggested using different suppliers due to his experience working as a locum. This had been agreed and authorised and had improved stock availability. The pharmacist had suggested providing the flu vaccination service. And this had been agreed. And the rest of the pharmacy team had also been trained to provide support.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided seating and healthcare information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. For example, they dispensed multi-compartment compliance packs and care home prescriptions in a rear area. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room. And it was professional in appearance.

Principle 4 - Services ✔ Good practice

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had a step free entrance. And a pressure operated door provided extra support to people with mobility difficulties. The pharmacy displayed its opening hours in the window. And displayed healthcare information leaflets in the waiting area and in the consultation room. The dispensing benches were organised. And the pharmacy team used dispensing boxes to keep prescriptions and medicines contained throughout the dispensing process.

The pharmacist had suggested providing the flu vaccination service. And this had been agreed and authorised. The pharmacy team had been trained about the service. And they were able to provide support. The pharmacist and the ACT attended a ‘pharmacy forum’ for pharmacies in the area. And they shared practice information and discussed new initiatives.

The ACT and the pharmacist spoke to people about their medication. And they registered suitable people with the chronic medication service (CMS) to support them to take their medicines as intended. The team members used trackers to dispense prescriptions before they were due. And they contacted people who failed to collect their medication on time. This helped to identify compliance issues which they then tried to resolve.

The pharmacy dispensed multi-compartment compliance packs for around 28 people who needed extra support with their medicines. And the pharmacy team had read and signed a valid SOP. They used trackers to manage the work-load. And this ensured people received their medication on time. The team members isolated packs when they were notified about prescription changes. And kept a record of changes in the communications book and a copy in the patient’s notes. The pharmacy supplied patient information leaflets and annotated descriptions of medicines in the pack. The pharmacy dispensed prescriptions for around 160 people in four care homes. The team members had read and signed the care home SOPs. But, the ‘interim dispensing’ process SOP had expired on 1 November 2018. And the pharmacy could not provide assurance that the dispensing process was as up-to-date as it should be. The team members managed the work-load so that it was safely provided. And dispensed one care home each week. The pharmacy dispensed methadone doses for around 10 people. And the pharmacist supervised the administration of the doses. The team members dispensed methadone doses once a week to manage the work-load. And they obtained an accuracy check at the time of dispensing and at the time of supply.

The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The

pharmacy held stocks of medicines used in palliative care. And team members carried out regular balance and date checks to ensure that medicines were available and fit for purpose. The team members kept the pharmacy shelves neat and tidy. And they kept controlled drugs in three well-organised cabinets. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperatures had remained between two and eight degrees Celsius. The pharmacy used a fridge for stock and another for dispensed items awaiting collection. The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked for aripiprazole in September 2019 with no stock found. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team had not been trained about its use and did not know when it was due to be introduced. The pharmacy team had learned about the valproate pregnancy protection programme. And they knew about the initiative and where to find the safety leaflets and cards. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to confirm that people had been provided with safety messages.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It uses crown-stamped measuring equipment. And the measures for methadone were highlighted and separated, so they were used exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.