General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 44-46 Victoria Street, NEWTON STEWART, Wigtownshire, DG8 6BT

Pharmacy reference: 1043036

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

The pharmacy is on a main road in the town centre. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And provides advice on the management of minor illnesses and long-term conditions. It delivers medicines to people's homes. And supplies medicines in multi-compartmental compliance packs, to help people remember to take their medicines. The pharmacy provides NHS services including the treatment for urinary tract infections, impetigo and minor ailments.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 team members continually monitor and review processes to identify and deliver improvements in the safety and quality of services. And consistently review and learn from the mistakes they make whilst dispensing.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages and supports the pharmacy team to learn and develop. And it engages its team members in regular learning to develop their skills and knowledge to help improve services.
		2.4	Good practice	Pharmacy team members are committed to working in an environment of openness and transparency. And they work together to support learning and development.
		2.5	Good practice	The pharmacy team members feel comfortable raising concerns and make suggestions to improve the running of the pharmacy. This helps support the safe and efficient delivery of the pharmacy services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy has robust processes in place to help identify and manage the risks associated with providing its services. And it ensures that people receive their medication with the required advice and support.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. They continually monitor and review processes to identify and deliver improvements in the safety and quality. The team members responsibly discuss mistakes they make during dispensing. And consistently review and learn from the mistakes they make whilst dispensing. The pharmacy keeps all the records as required, by law in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions, high-risk medicines and controlled drugs (CD) management. The company reviewed these and every quarter sent out some for the team to read. The team completed quizzes at the end to test their understanding. The team could advise of their roles and what tasks they could do. There were also several other corporate checks undertaken weekly to manage the running of the pharmacy. The pharmacy workflow provided different areas for dispensing activities with dedicated benches for assembly and checking and a separate room for compliance pack preparation. They used two computer terminals in the dispensary. And had a third one in the consultation room. The pharmacy team members used tubs throughout the process to keep prescriptions and medicines together. They added laminated cards which indicated if people were waiting or calling back for their medicines. And they received the prescriptions collected from the surgery and after collection they worked through these and placed these in a different area. This helped plan the workload.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these on a specific template. Each member of the team had their own form. The team members were encouraged to review their form each week for any mistakes made and to try to think how the mistake had occurred and ways to improve. An example included pregabalin with the wrong strength and the dispenser had recorded that they were focusing on the drug so much they picked the wrong strength and had not noticed. Another example was when the dispenser had dispensed Shortec instead of Sevredol. The patient safety champion was one of the dispensers and she put together the monthly report. And the pharmacist reviewed and signed. The team members all read and signed the reviews. And they placed it on the wall for the following month with notes of the focus points. The team held meeting for the monthly review. The team had discussed the use of the pharmacist information forms (PIFs) and discussed the need to record something clinical. The team members now recorded if people had received an item before with 'hb'. This reassured the pharmacist that the team member had checked the prescription for previous history. The team had adopted this process for a couple of months and the team were embedding this well. The patient safety champion provided a separate review for any near miss errors with the compliance packs. Learning from the compliance pack review

included a reminder to put away split packs promptly to ensure these would get used first and that there would not be too many split packs on the shelves. Learning from the main dispensary had included a change in the checking of the running balances for methadone. This had occurred as there had been several arithmetical errors. So, now the dispensers were checking the additions at the end of each day as it was easier to sort any errors rather than leaving for the week.

The pharmacy provided a separate monthly patient safety review for any new starter as their focus was often different when they were learning. And it was useful for them to have their own focuses, particularly in the earlier stages of their training. The pharmacy team had displayed the new Look-Alike Sound-Alike drugs (LASA) list at the computer terminals. The pharmacy had just received the new version which now included gabapentin and pregabalin. The team had discussed to remember to include these on the PIFs at the patient safety meeting previously. The team had various shelf alerts with 'Select it, speak it', at the most common errors in the company. And some of their own. The team reviewed patient safety and had an exercise where they copied some prescriptions as exemplars, with confidential details removed. They had a mixture of some with errors and others without. They had used examples from their own near misses. And they gave then to team members to do. The manager advised that the new starters liked doing these to learn.

The pharmacy had a patient guide which explained the complaints process to people and how they could provide feedback. The pharmacy had 'share your thoughts' cards at the counter which people could take to complete if they wanted. The team members knew how to record any complaints received on the internal system, PIERs. And if there were any these were discussed when applicable. And included on the monthly patent safety review for learning. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. The pharmacy had completed the CD registers ,looked at, as required with headings complete and running balances maintained. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. It kept private prescriptions as required and made the appropriate entries electronically. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The team had read General Data Protection Regulation (GDPR) information and completed e-Learning on this. The pharmacist had undertaken training through NHS Education for Scotland (NES). The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for offsite shredding. And kept records and any paperwork confidential. Safeguarding information including contact numbers for local safeguarding were available for the team. If a team member had a concern about a child or vulnerable adult, they would discuss this with the pharmacist in the first instance. The new starter would undertake the e-Learning on this as soon as possible but was aware to ask any of the team regarding anything she was unsure of.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has good systems in place to make sure it has enough staff with the right skills to provide its services. The team members understand their roles and responsibilities. The pharmacy encourages and supports the pharmacy team to learn and develop. And it engages its team members in regular learning to develop their skills and knowledge to help improve services. Pharmacy team members are committed to working in an environment of openness and transparency. And they work together and support each other in their day-to-day work. They contribute to regular shared learning exercises relating to risk management and safety. They feel comfortable to discuss their development needs and raise any concerns if necessary.

Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT) and two dispensers working in the pharmacy. The was a new member of staff who had started that day who was going to be a dispenser. In addition, there were two other dispensers who worked at the pharmacy. The ACT was the manager of the pharmacy and worked 37.5 hours weekly. There was a regular pharmacist at the current time. Three of the dispenser roles were for 37.5 hours, one for 30 hours and the other 28 hours weekly. One of the dispensers was on maternity leave and the hours were being covered by other members of the team and help from other nearby branches. The dispenser who was on maternity leave had recently had a 'Keep in touch' day and was going to be doing two days a month until her leave finished, and she returned to work. There had been a change in staffing recently with two dispensers leaving but their hours had been mostly covered by the new starter. The store manager advised that they were slightly over in hours if everyone was working a full week, but this had been good for training with new members. This allowed flexibility with training.

The team members received protected time for training and completed training on the company's e-Learning and on 30-minute tutors. The team undertook quizzes on topics covered in the training, each quarter. This ensured understanding of topics covered. The required training was up-to-date. The most recent training had been on Digital Pharmacy which was the process for people to order their own prescriptions. The team used the company internal magazine, The Professional Standard for training. And they had discussions on the scenarios and the drug of the month for continued learning. The new starter was under taking the induction programme on the computer. And was being looked after by the team to help her settle. She was undertaking the compulsory e-Learning on Working at height, Health and Safety and Fire as a priority. She was then going to read some standard operating procedures (SOPs). She was receiving training on the tills and the healthcare way process. And would read the SOP for taking-in and handing-out a prescription as a priority. A member of the team would help and supervise her until she was comfortable doing this. Certificates and qualifications were available for the team. And displayed in the dispensary.

The team received performance reviews every four months which gave them the chance to receive feedback and discuss development needs. One of the dispensers had worked as a counter member of the team for about 12 years and had recently completed the dispensing course. She particularly liked organising the compliance packs so managed these. The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone

queries. The team had been involved in rearranging the storage area for the compliance packs. And how they managed the workload for these. They had changed the preparation of the packs to different weeks which had spread the workload more evenly. And meant that there was no week which was busier than others for preparing the packs. The team said they could raise concerns about any issues within the pharmacy by speaking to the manager, pharmacist or the area manager. There was a whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team kept a cleaning rota to ensure they maintained this. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team promoted for use. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy had an additional discreet room for the substance misuse service. This room was bright and well lit.

Members of the public could not access the dispensary due to the location of the counter. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises. There was a buzzer on the door which alerted the team members to anyone entering. And they acknowledged and attended to them when they entered the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. The pharmacy has robust processes and systems in place to help identify and manage the risks associated with providing its services. And it ensures that people receive their medication with the required advice and support. The pharmacy gets its medicines from reputable sources. And it has systems in place to ensure medicines are safe and fit to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all. There was a power-assisted door at the entrance to the pharmacy. There was some customer seating. And a working hearing loop in place. The pharmacy displayed its services in a ladder at the entrance to the pharmacy. The hours of opening were on the door. The pharmacy displayed a range of health care leaflets on a variety of topics, including cancer, sepsis and malaria. And a current topic for prostate buddies which promoted local support. At the counter and in the window the pharmacy displayed information about the flu vaccination service to remind the local population of the dates the surgery was holding clinics for the service. The team advised people that if they required a flu vaccination privately then the nearest Boots pharmacy, proving the service was in Stranraer. There were posters in the waiting area with information about the minor ailments scheme, urgent supplies of medicines, services for urinary tract infections and impetigo. The pharmacy had a defined professional area. And the team members assisted people if they wished to purchase any pharmacy medicines.

The pharmacy provided the NHS chronic medication service and it had about 15 people who obtained serial prescriptions through this service. The team members have spoken to the surgery and they have identified more people who would benefit from serial prescriptions. This was work in progress. The pharmacist and accuracy checking technician (ACT) provided the smoking cessation service. They had undertaken the relevant Health Board training and undertaken updates through Boots e-Learning. The pharmacy provided the Emergency Hormonal Contraception (EHC) service with about five requests a month. The pharmacy provided the minor ailments service which was popular for itchy eyes, skin problems and hay fever. It used the unscheduled care service a lot. And this eased the pressure on the surgery if people ran out of a regular medicine. The team members provided people with the item and counselled them on ordering in time in the future. They used this for synchronising people's medicines which helped them when reordering in the future. They provided trimethoprim for urinary tract infections and often received requests from the surgery to see people. They provided Fucidin for impetigo and flucloxacillin for skin infections which was popular in the summer. They provided chloramphenicol for eye infections for children over one year and people on the minor ailments scheme.

The local surgery had set up a local hub were there were practice pharmacists and other prescribers. This had been set up about two months ago and the pharmacist advised that they liaised with the hub especially if there were difficulties in obtaining items. And they could advise suitable available alternatives. They could advise the nurses on dressings which were available. The pharmacist advised she also referred people to the nurse for appointments rather that the doctors and many had not realised that nurse could prescribe for certain conditions.

The pharmacy supplied medicines to around 50 people in multi-compartmental compliance packs to help them take their medicines. All the trained members could dispense the packs but generally it was one dispenser who undertook most of them. The team members used the company Medisure progress logs to monitor the progress of the packs and when they required to order medication ready in time for the supply. They used patient profiles for all people. And updated these and replaced them if there were any changes. They kept previous versions in people's files for reference. They prepared four weeks at a time. And included descriptions of medication on the labels and provided patient information leaflets (PILs) at the start of each cycle. They kept a file in the room with the commonly used PILs required when they dispensed from bulk containers. This ensured that people received the PILs. The team used the communications record book for any information regarding any person's pack. And kept the copy with their profile for reference and required action. The team members used the purple instalment form for controlled drugs for tracking any CDs supplied in packs. And entered this on the form as a guide for them. They found this useful to ensure they made the supplies correctly. If the team members removed any medication from a pack, they placed these in a white skillet and marked on what they had removed with the quantity noted. This assisted the pharmacist or ACT when checking the item. They had dedicated shelves where they placed any packs if they had any changes to them, one for packs ready to check and then they placed packs ready for packing for supply. The team used the collection dockets and people signed these when collecting the packs. The pharmacy delivered a few packs to people, but his number had dropped with the recent introduction of a charge. People arranged to collect or for a representative to collect on their behalf.

The pharmacy offered a substance misuse service and provided several people. A few people received sugar free methadone and the others received ordinary methadone. And a few received buprenorphine. The team members put the dates of supply on the end of the boxes for buprenorphine which assisted in the handing out process. Most of the methadone people were supervised on the day of collection with a few daily and others collecting three or four times a week. The pharmacy made up the supplies weekly and undertook balances checks before making the week's supply. The pharmacy provided a needle exchange service and undertook about four to five transactions a week. In the room where the pharmacy made the supplies there were several posters with useful information on related items such as naloxone. There was a notice reminding people how to remember to give their unique code when using the needle exchange service. This assisted people and prompted them how to remember the requirements.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team used a quadrant stamp on the prescription to show that the pharmacist had completed a clinical check. It also showed who had labelled, dispensed, accuracy checked and handed out the items. The ACT generally checked the compliance packs.

The team members used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out. The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over to add these items. The CD stickers had a space to record the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. There was a selection of laminated cards which the team used to add to the tubs during the dispensing process to raise awareness at the point of supply. These included warfarin, methotrexate and lithium which ensured patients received additional counselling. They also completed the pharmacist information forms (PIFs) with any required information such as to text once completed.

They noted the date of the previous supply for any CDs to check that the people were not ordering this too soon and over using. They recorded the date for the last supply and on occasions they noted the pharmacy could not make the supply as the prescription had been post-dated. They noted on all PIFs if there had been no change in medication or if it was a new person they noted that there was no history. The pharmacy team noted on PIFs if any of the items dispensed was one of the Look-Alike Sound-Alike (LASA) drugs or one of the drugs with the laminated cards such as warfarin. This highlighted the extra vigilance when dispensing and checking. The new starters, when training, highlighted the dispensed by box on the QUAD stamp if they had dispensed the prescription, as well as initialling, to alert the pharmacist. The pharmacy started trainees doing prescriptions with one item, then two and gradually building this up.

The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They had a notice displayed at the main dispensing bench as a reminder. The pharmacy had undertaken an audit and had only one patient who they had provided with the information. They explained the information they provided. People ordered their own medication except for the compliance packs. The pharmacy took in people's repeat prescription forms It had a box where people could place the repeat slip for this service or people handed the slip in at the counter. There were notices reminding people who used this service when their items would be ready for collection at the pharmacy. The team reminded people if they handed then the slip when their medicines would be ready for collection. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs. The driver worked afternoons only.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. The pharmacy used recognised wholesalers such as Alliance, AAH and Phoenix.

Some of the pharmacy members were aware of the Falsified Medicines Directive (FMD). The manager advised that they were getting a new computer next year and understood this would be ready for implementation of FMD. The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. They discussed any alerts and recalls at the monthly patent safety review.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways to protect people's confidentially.

Inspector's evidence

The pharmacy team members had access to a range of up to date reference sources, including the British National Formulary (BNF). They used the resources on the Boots system, medicines complete, as an additional source for information. This included the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone which it kept in a separate location. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves and alcohol hand washing gel.

The pharmacy stored medication waiting collection on shelves and people at the counter could not see any confidential information. The team filed prescriptions in a retrieval system out of view, keeping details private.

The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used cordless phones for private conversations.

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.