General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 76 Barry Road, CARNOUSTIE, Angus, DD7 7QU

Pharmacy reference: 1091897

Type of pharmacy: Community

Date of inspection: 28/01/2020

Pharmacy context

This is a community pharmacy beside a GP practice. It dispenses NHS and private prescriptions. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also offers smoking cessation and substance misuse services. And it offers seasonal flu, meningitis and human papilloma virus vaccination. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines.

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	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 follow 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 mistakes happening again. The pharmacy uses people's feedback to try to make pharmacy services better. The pharmacy keeps all the records that it needs to. And it 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. 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. Experienced team members could undertake all activities in the dispensary and medicines counter. They followed a rota which the accuracy checking pharmacy technician (ACPT), trainee technician or pharmacist completed each morning. This ensured that team members did not become bored or complacent with tasks and maintained skills and knowledge in all areas. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. It had a well-defined process to enable the ACPT to undertake final accuracy checks. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

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. The ACPT reviewed all near misses monthly and introduced strategies to minimise the same error happening again. These included labelling shelves to highlight items involved e.g. 'Select with care' labels for amitriptyline and risperidone; 'Speak out loud' labels for quinine and rivaroxaban. The ACPT had recorded near misses she had made recently due to distractions. One incident had occurred as she was rushing and not following her usual process to check a prescription. It had not been ready as a person had expected, so she had rushed to complete it while the person waited. She discussed incidents and patterns with team members individually as there was little opportunity for team members meeting together. The main reasons given for errors were distraction due to interruption when dispensing. Often there was no medicines counter assistant working so dispensing team members had to manage the counter while undertaking dispensing activities. The ACPT had reminded all team members to work on their own checking protocol and ensure all items were double-checked before passing for the final accuracy check. Often people presented at the pharmacy early to collect their prescriptions which meant that collection service prescriptions became waiting prescriptions, increasing pressure and risk. The pharmacist added errors that had reached people after the ACPT had undertaken her review. Only the pharmacist had access to the company electronic error reporting system to capture this data. This meant that the review and discussion with team members may not include all incidents. The ACPT had undertaken a recent review on 7 January but this did not include errors that had occurred in December. The inspector observed a few incorrect medicines (errors)stored in a cupboard that had been reported internally but not yet included on the monthly review.

The area manager had recently reviewed the dispensing process in this pharmacy which had resulted in a change of process. The ACPT now worked on a bench between two labellers, close to the phone and in view of the medicines counter. This enabled her to have access to patient medication patient records if required. But during the inspection this was observed to be challenging as she was interrupted from the medicines counter on several occasions. And there were other team members labelling beside her. This created noise and made the area feel crowded. There was a more discreet area of the dispensary which was largely used for collection service dispensing, with little distraction. At the time of inspection there was no-one working there as all team members were in other areas undertaking other dispensing. The ACPT had previously undertaken accuracy checking in this area. Team members were monitoring and reviewing the effectiveness of this new way of working.

The pharmacy had a complaints procedure. Most feedback was related to prescriptions not being ready when people expected. Many people expected their prescriptions to be ready sooner than was possible. The pharmacy had placed a timetable on the medicines counter to remind people what day medicines would be ready for collection, related to the day prescriptions had been ordered. Despite this many people presented at the pharmacy early which was time-consuming for team members trying to locate prescriptions. Then risk was increased as they dispensed these under pressure. They were working at trying to find ways to explain to people the time required to supply their medicines. Team members were observed to be very polite and obliging.

The pharmacy had an indemnity insurance certificate, expiring 30 April 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 undertaken mandatory annual training on the topic. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken training on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to provide its services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Team members can share information and raise concerns to keep the pharmacy safe. 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; one part-time pharmacist, three days per week; one part-time ACPT working daily from 11:30am until 6:15; one part-time trainee pharmacy technician four days per week; one full-time and three part-time qualified dispensers; two part-time trainee medicines counter/dispensing assistants; one part-time medicines counter assistant working mornings only and delivery drivers from the Boots hub. Typically, there were one or two pharmacists (two on Wednesdays, Thursdays and Fridays), four dispensers and a medicines counter assistant in mornings, and two or three dispensers and the ACT to the in afternoons. At the time of inspection, the pharmacist manager was on annual leave, the planned double pharmacist had been cancelled and a dispenser was absent. The trainees had started in the pharmacy recently following a review of staffing. Some hours were replacing a long-term absence. Team members were able to manage the workload, but it was challenging at times especially in afternoons when there were fewer dispensers, no medicines counter assistants and a large volume of prescriptions was received around lunchtime. At the time of inspection, the prescriptions from the previous day had not yet been dispensed. One dispenser was working continuously on prescriptions for people waiting and another was labelling the collection service prescriptions. The ACPT was checking, so there was no one to dispense the collection service prescriptions. The pharmacist was checking prescriptions for people waiting. The ACPT explained that she could dispense, and had spells of doing so, but then could not check them. With only one pharmacist a backlog of checking would build up. Around mid-afternoon, a queue of around seven people was observed. The pharmacist was serving people at the medicines counter with queries, a dispenser was dealing with another query a second dispenser was dispensing prescriptions for people waiting and the ACP the was dispensing balances for items that had been out of stock for a long time and just been received. This meant that for a period there was nobody available to check prescriptions (prescriptions for people waiting had not been accuracy checked so needed to be checked by the pharmacist) and nobody to dispense the collection service prescriptions. This was sustained.

The pharmacy provided learning time during the working day for all team members to undertake e-learning modules when they were received. It provided team members undertaking accredited courses with additional time to complete coursework. The trainee pharmacy technician described being given half a day at the end of the week to undertake her coursework, when they were more staff. She also did some at home in her own time. The two trainee medicines counter/dispensary assistants had started work in the pharmacy around three months previously and had not yet started working through their accredited training programme. As they were at very early stages of the training, they were limited in the activities they could undertake. They were supervised by experienced team members which was sometimes time-consuming. The pharmacists had undertaken appropriate training for delivery of vaccinations. Team members had annual development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives for the part-time

pharmacist included coming more involved with the business. But she explained this was challenging as she was so busy with dispensing tasks. Team members 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.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They each had their own near miss log, and the ACPT kept her own for the whole team. Sometimes she compared the two versions to ensure that all incidents were being recorded. This had recently improved. The team had worked together to improve their recording of incidents. 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. They gave appropriate responses to scenarios posed. The pharmacy superintendent sent a regular document, the 'professional standard', which included sharing information and incidents from elsewhere in the organisation for all team members to learn from. It also included colourful reference material to support dispensing accuracy. Team members read this document and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks when they could during the working day. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members explained that they were encouraged to sign people up to services such as repeat collection service and chronic medication service. This was included in the pharmacy plan which was on the wall in the dispensary.

Principle 3 - Premises ✔ Standards met

Summary findings

The 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. Other people cannot hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, staff facilities and limited storage space. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were able to see activities being undertaken in the dispensary. Dispensers were sometimes interrupted and distracted by people at the medicines counter. 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 door was kept locked to prevent unauthorised access. The pharmacy also had a second consultation room which was mostly used as an office. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provide 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 appropriately. 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 level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as travel vaccination, and people requiring multi-compartment compliance packs were directed to a branch nearby with more capacity to do this. 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 coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. And they used pharmacist information forms (PIFS) with all prescriptions to share information with the pharmacist. 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. This enabled the ACPT to accuracy check suitable prescriptions. The process was observed to be logical and methodical. One dispenser was working on prescriptions for people waiting, another was labelling collection service prescriptions, and another was dispensing. But there was no medicines counter assistant, so dispensers were constantly interrupted and distracted to attend to the counter. Prescriptions had not been dispensed from the previous day, mainly due to some staff absence. Team members were spending time looking for prescriptions. When collection service prescriptions were received, a team member scanned them onto the system and put them into alphabetical order. This meant that when people were looking for prescriptions they could be located. A team member then labelled prescriptions and placed them in a basket for dispensing. At the time of inspection there were labelled prescriptions for around 150 people from the previous day. A dispenser was working through them, but she finished for the day at 2.30pm. Meanwhile another dispenser was labelling prescriptions that had been received that day. These had already been scanned into the system and put into alphabetical order. There were around 150 of these. For a short time during the inspection team members were not dispensing as they were dealing with other prescriptions and people. The pharmacist dispensed a prescription for a person waiting and the ACPT accuracy checked it. When people were looking for prescriptions team members followed a methodical process to locate them. The pharmacy had around 450 items waiting to be assembled which would not be completed by the end of the day. Team members explained that they would probably get caught up at the end of the week when there were more team members. There was a medicines counter assistant working at the end of the week, so dispensers had fewer distractions. The pharmacy signed people up for a text message service, to text them when their prescription medicine was ready to collect. But before Christmas, the pharmacy was running around five days behind with collection service prescriptions. Therefore, people did not get their text messages when expected. This had reduced their confidence in

the service. So, people were continuing to come to the pharmacy early, before the text had been sent. And sometimes the GP practice told people prescriptions would be ready in 48 hours. But this referred to the time it took to generate the prescription and did not include time for the pharmacy to assemble medicines.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. The pharmacy did not routinely assemble multi-compartmental compliance packs. Another pharmacy close-by that had more capacity did them. The two pharmacies had liaised and decided a few years before that it was better to assemble them all in one pharmacy – all prescriptions came from the same surgery. This pharmacy was open longer hours so if there was an urgent prescription after the other pharmacy was closed team members were trained and competent and had equipment to provide the service.

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. 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 vaccinations. 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.

Both pharmacists were trained and competent to deliver vaccinations. They undertook these using an appointment system on days when they were both working. The smoking cessation service was delivered by the ACPT, the full-time dispenser, and the trainee technician. The pharmacy had arranged for the NHS smoking cessation coordinator to come to the pharmacy one evening and train all team members. Following consultations, team members shared information with the pharmacist who prescribed appropriately following the PGD.

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 team members acted 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 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 equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and sundries and emergency equipment required for vaccination. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They kept clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in locked cupboards in the consultation room, and in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented personal information being seen by any other people. 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.