

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 6, Happyhillock Shopping Centre,
Happyhillock Road, DUNDEE, Angus, DD4 8LS

Pharmacy reference: 1092421

Type of pharmacy: Community

Date of inspection: 14/11/2022

Pharmacy context

This is a community pharmacy within a small local shopping precinct in Dundee. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use.

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 is good at recording things that go wrong so that it can learn from them. It is good at providing feedback to individuals and to the whole team. And they take action to prevent similar incidents occurring in the future.
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 identifies and manages the risks associated with its services. And pharmacy team members follow written procedures to help them work safely and effectively. The pharmacy keeps good records of the mistakes that happen during the dispensing process. Members of the team use the records to learn from their mistakes. And they take action to avoid problems being repeated. They keep the records they need to by law, and they keep people's private information safe. The team is adequately equipped to manage any safeguarding concerns.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and team members were wearing face masks to prevent risk of infection.

The pharmacy had a set of written standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. The SOPs covered tasks such as dispensing and selling medicines. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the pharmacist. SOPs had been reviewed by all team members within the last year. The pharmacy employed an Accuracy Checking Technician (ACT). Team members were able to describe the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. The pharmacy had a business continuity plan with clear procedures to follow to address disruption to services or unexpected closure. Team members were able to describe the process for branch closure when there was no responsible pharmacist available. The pharmacy had a documented process for notifying key stakeholders if the pharmacy was forced to close including contact details for vulnerable people who were due to collect medication during the period of closure.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as 'near misses.' And they recorded errors that had been identified after people received their medicines. One team member explained their role as 'patient safety champion.' They had created a patient safety board to co-ordinate all communications around patient safety. The pharmacy superintendent shared information about incidents from elsewhere in the organisation for all team members to learn from. This document was prominently displayed on the safety board. Team members signed the document to confirm they had read it. The team had a monthly safety meeting to review near misses and errors so that they could learn from them. And they took action to help minimise the chances of the same error happening again. The patient safety champion gave individual team members feedback on their errors. They explained how team members were given SMART-ER (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluate, Re-do) objectives for personal development following these discussions. Team members created a detailed plan of changes they made, with evaluation and reflection to ensure the actions were effective. The pharmacy had a complaints procedure.

The pharmacy had current indemnity insurance. The pharmacy displayed the correct responsible pharmacist (RP) notice and had an up-to-date responsible pharmacist record. Private prescription records appeared to be in order, including records about emergency supplies and veterinary prescriptions. And the records for unlicensed medicines were complete. The pharmacy kept controlled

drug (CD) records with running balances. A random balance check of three controlled drugs matched the balances recorded in the register. Stock balances were checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. Electronic patient medication records (PMR) were regularly backed-up to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. When questioned, they were able to demonstrate an understanding of data protection and had completed general data protection training. They separated confidential waste for secure destruction offsite. No person-identifiable information was visible to the public. The pharmacy had a documented procedure and contact details to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place. The pharmacist was registered with the protecting vulnerable group (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service.

Inspector's evidence

The pharmacy employed one full-time pharmacist, a part-time accuracy checking technician manager (ACT), two pharmacy advisors, and two trainee pharmacy advisors. Team members were seen to be managing the workload. Two team members spoken to during the inspection were experienced in their roles and had been working at the pharmacy for several years. Two trainee pharmacy advisors were observed being supervised in their role and were able to describe the training plan that they were working through. All team members demonstrated a good rapport with people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. Team members asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when unsure. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

The pharmacy planned learning time during the working day for all team members to undertake regular training and development. It provided team members undertaking accredited courses with additional time to complete coursework. Team members had quarterly development meetings with the manager to identify their learning needs. They understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. And they felt able to make suggestions and raise concerns to the manager. The team had regular monthly team meetings. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is suitable for the services it provides. The premises are clean, secure, and well maintained. And it has a suitable room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were average-sized, incorporating a retail area, dispensary and back shop area including storage space, an office, and staff facilities. They 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. The pharmacy's overall appearance was professional. It had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed which provided privacy. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply. And the pharmacy team provides appropriate advice to people when supplying medicines to them.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a power-assisted door. And the central pharmacy counters were low in height for those using wheelchairs. The pharmacy advertised some of its services and its opening hours in the main window. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used tubs to separate people's medicines and prescriptions. And they attached coloured labels to people's dispensed medicines to act as an alert when they were handed out. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. Team members added their initials to 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. Many people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these in advance, usually seven days before they were needed. Team members checked if people needed each prescribed item when they came to collect, in order to avoid waste. And they maintained records of when people collected their medication.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The pharmacy managed the dispensing and the related record-keeping for these on a four-weekly cycle. It kept master backing sheets for each person in folders for each week of assembly. Records of changes to medication were observed and the pharmacy retained written communication from the patient's general practice. This included copies of discharge letters or notification of change forms. This created a clear audit trail of any medication changes. Compliance packs were labelled clearly with directions and descriptions then stored on neat and tidy shelves pending supply. The pharmacy supplied a high volume of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including methotrexate, lithium, and warfarin. People were supplied written information and record books if required. Team members were aware of the risks involved in dispensing valproate to women in the at-risk group. The team highlighted these prescriptions with a specific-coloured labels. These prompted staff to check key safety information with the person collecting the prescription. And patients were counselled and provided with cards highlighting the importance of having effective contraception. But the team recognised that they could do more to

record the outcomes of some conversations. They identified an opportunity to record interventions within the patients' medical record.

The pharmacy had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, and emergency hormonal contraception (EHC). The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. 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.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines in original packaging in drawers and on shelves. Items requiring cold storage were stored in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of stock medicines. A random sample was inspected and all were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. Team members followed the sale of medicines protocol when selling these.

The pharmacy printed recalls and safety alerts on receipt. Once actioned, records were kept in a folder. But the records did not include the action taken, date or member of the team involved, so the pharmacy was not able to demonstrate that recalls had always been handled appropriately. Team members had 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 to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had internet access allowing access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy had a range of crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. Team members used a pump for measuring doses of methadone on a weekly basis. The pump was sent for calibration annually, as recommended by the manufacturer. Team members cleaned it at the end of each day and poured test volumes before use. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in locked filing cabinets in the dispensary and office inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented people's information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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.