General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 21-23 Castle Street &, 70 Buccleuch Street, DUMFRIES, Dumfriesshire, DG1 1DJ

Pharmacy reference: 1097966

Type of pharmacy: Community

Date of inspection: 23/07/2024

Pharmacy context

This is a busy pharmacy in the town of Dumfries in Scotland. Its main activity is dispensing NHS prescriptions. It provides some people with their medication in multi-compartment compliance packs to help them take their medicines correctly and it provides a range of NHS services including Pharmacy First. It has a delivery service, taking medicines to people in their homes.

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	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's written procedures help team members manage risk and provide services safely. Team members record errors made during the dispensing process to learn from them and they make changes to help prevent the same mistake from happening again. They mostly keep the records required by law and they keep people's private information secure. Team members have the necessary training to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These were reviewed by the company's superintendent pharmacy (SI) team every two years. Team members accessed newly updated SOPs on an electronic platform when they were released. They completed quizzes to confirm their understanding of them and compliance with completion was monitored by the pharmacy manager. Team members were up to date with the SOPs.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who made the error recorded the details about it, or if they were not present when the mistake was identified, the pharmacist recorded the details and discussed it with the team member upon their return. Details were recorded electronically. Team members were unable to access details about previous near misses during the inspection as this could only be done by a manager and the manager was not present. Team members shared responsibility for completing a monthly patient safety review and took turns completing this according to a rota. The patient safety review for June had been completed. And mistakes involving wrong forms, quantities and directions had been identified as the most common mistakes. Team members discussed the patient safety review together and suggested changes to help prevent the mistakes from occurring again. For example, they had separated different forms of the same medicine from each other on the shelves where they were kept. And they completed double checks with each other for medicines that could not be scanned using barcode technology to improve accuracy. The pharmacy completed incident reports for errors that were identified after a person had received their medicine. These were recorded electronically and shared with the area manager and the head office team if necessary. Team members had implemented a change in their processes after the most recent dispensing incident. This involved marking the prescription with the prescribed duration to ensure the correct quantity was issued each time to people. The pharmacy had a complaints policy which was detailed in the pharmacy's practice leaflet. Team members aimed to resolve any complaints or concerns informally. And any complaints that could not be resolved were escalated to the area manager or people were provided with the number for the company's customer care team. Team members sought regular feedback from people accessing the services by asking them to fill out a survey linked to a QR code. Feedback was shared with team members and was positive.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. The pharmacy's accuracy checking pharmacy technician (ACPT) had discussed with their line manager as to what they felt comfortable to check. Team members were aware of the tasks that could and could not take place in the absence of the responsible pharmacist (RP). The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP record was completed correctly. The pharmacy had a paper-based register for

recording the receipt and supply of its controlled drugs (CDs). The entries checked were mostly complete with the exception of the address of the wholesaler which was not recorded for received medicines. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. And they were stored separately to ensure they were not mixed with stock medicines. The destruction of returned CDs was witnessed by two team members, and this was an ACPT and pharmacist. Destruction of out of date CDs had been completed the day before the inspection, and only signed by one of the team members who carried out the destruction. The pharmacy kept certificates of conformity for unlicensed medicines and details of who the medicines were supplied to, which provided an audit trail. It kept complete electronic records for its supply of private prescriptions and kept associated paper prescriptions.

The pharmacy had a company data processing notice and NHS Pharmacy First data processing notice on display in the retail area which informed people of how their data was used. Team members received annual training regarding information governance and General Data Protection Regulation. The pharmacy separated confidential waste for collection and secure destruction. Team members received annual training for safeguarding of vulnerable adults and children. They knew to refer any concerns to the pharmacist in the first instance. They had access to contact details for local safeguarding teams and other healthcare professionals involved in people's care. All team members were registered as part of the protecting vulnerable groups scheme. The pharmacy displayed a chaperone policy in the consultation room which informed people of their right to have a chaperone present during consultations.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and competent team members to help manage the workload. Those in training receive appropriate support to complete their courses. And other team members complete ongoing training to help develop their skills and knowledge. They suitably respond to requests for sales of medicines and support people with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was a relief pharmacist employed by the company. They were supported by three trained dispensers, one of whom was completing training to become a pharmacy technician, and a trainee dispenser. The pharmacy further employed team members who were not present during the inspection. These included a regular pharmacist, a trained dispenser who was beginning training as a pharmacy technician, two further trained dispensers and an ACPT who also worked in another of the company's pharmacies. And there were drivers provided to complete the pharmacy's deliveries. Team members had either completed or were in the process of completing accredited qualification training for their roles. The regular pharmacist acted as tutor for the trainees and had regular meetings with them. Team members who were undertaking training received protected learning time in the pharmacy where possible and completed extra learning at home where necessary in order to progress through their learning in a timely manner. A team member in training explained that any requests from people for medicines they had not yet completed training about were referred to the pharmacist. Team members who had completed their training were given regular opportunities to develop their skills and knowledge through company-issued training. And they explained the most recent training was about giving people advice to help them take codeine safely and reading updated SOPs. They received a monthly newsletter from the SI team which provided information and learnings from other pharmacies in the company. The pharmacist had completed training to provide the NHS Pharmacy First service and had read the associated patient group directions (PGDs). They had also completed training to become an independent prescriber (IP) and the regular pharmacist had also recently gained this qualification.

Team members were observed to work well together and were managing the workload. There was an open and honest culture, and they felt comfortable to raise professional concerns with the pharmacy manager if necessary. And they made suggestions for changes in the pharmacy, which included introducing a rota which meant a team member was always present at the medicines counter. Team members did not receive performance reviews but received informal feedback from the manager when needed. And if they wanted to develop their skills and knowledge by undertaking additional qualifications, they could raise this with the pharmacy manager. Annual leave was planned in advance by the pharmacy manager so that contingency arrangements could be made. Team members changed their shift patterns and increased their hours to help support periods of absence.

Team members knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist or pharmacy manager who would have supportive conversations with people. The pharmacy set its team members targets, but they did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy comprised of a large front retail area and a long dispensary. And there was a storage area through a secured door from the retail area. There was a small medicines counter and a barrier between the medicines counter and dispensary which prevented unauthorised access to the dispensary. There was a single long bench in the dispensary which had different workstations and provided enough space for different tasks to be completed comfortably. The pharmacist's checking bench was positioned in the dispensary so they could supervise the dispensary easily and intervene in conversations at the medicines counter if necessary. A small private area with swing doors situated adjacent to the dispensary provided privacy for people who had their medicines supervised. The dispensary had a sink which provided hot and cold water. Toilet facilities and an area where team members had their breaks were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable. Team members kept the pharmacy clean.

The pharmacy had a lockable soundproofed room accessed from the retail area which allowed people to have private conversations and access services. The room was spacious and remained locked when not in use. There was a desk, chairs and a computer. It had a sink, but this was currently out of order.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members complete regular checks on medicines to ensure they remain fit for supply. They provide people with relevant information to help them take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had a step up into the retail area from the street. Team members made this accessible to those using wheelchairs or with prams by offering the use of a portable ramp. And from the team members position at the medicines counter, they could clearly see people requiring assistance and assisted them at the front door. The pharmacy provided people with large print labels if they had any visual difficulties. And they used translation applications to assist those whose first language was not English. The pharmacy had a range of healthcare leaflets for people to read or take away. For any services they did not offer, such as travel vaccinations, team members signposted people to other nearby pharmacies in the company who did offer the service.

Team members used containers to keep people's prescriptions and medicines together and reduce the risk of errors. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Laminated cards were attached to the prescriptions to highlight fridge lines, CDs, or higher-risk medicines such as valproate. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine effectively. They were aware of recently updated legislation for providing valproate in the manufacturer's original packs but had not yet completed a risk assessment for those who received their medicines outside of the manufacturer's original pack. Team members asked appropriate questions when handing out medicines to ensure they were provided to the correct person. They provided people with an owing slip, which was a record of medicines they could not provide the full quantity of. And they checked prescriptions with owed medication twice daily and used a tracker to record action that had been taken. This included if an alternative had been sought from the person's GP if the medicine was out of stock.

The pharmacy provided the NHS Pharmacy First service. The service was underpinned by PGDs, and the pharmacist accessed the most up to date versions of these online. The pharmacy supervised the administration of medicine for some people. Team members managed the service by preparing the medicine on a weekly basis so that it was ready for people to collect. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions in advance so that any queries regarding a person's medication could be resolved in a timely manner. Each person had a medication record sheet which detailed the medicines and administration times. Any changes to a person's medication were communicated from the GP surgery or via hospital discharge letter. Team members recorded the information in a communication book and completed a new medication record sheet with the most up to date information once the prescription had been received. They supplied people with the descriptions of the medicines in the pack so they could be easily identified. And they provided people with the patient information leaflets once a month so they could read about the medicines they were taking. The pharmacy provided a delivery service taking medicines to people in their homes. Team

members added deliveries to an online platform once they had arranged a suitable time for people to receive their delivery. And they could highlight on the electronic platform if a CD or fridge line was to be included in the delivery. The drivers used an electronic device as a record of the deliveries to be made and asked people to sign it to confirm receipt of their delivery. For any medicines that were unable to be delivered, they left the person a note of failed delivery and returned the medicine to the pharmacy.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on the dispensary shelves. Pharmacy only (P) medicines were stored behind the medicines counter which ensured the sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. And records showed this was up to date. They highlighted medicines expiring in the next three to six months for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. A random check of medicines found all were in date. The pharmacy had two fridges to store medicines that required cold storage. Team members recorded the temperatures daily and records showed the fridges were operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email and directly from the company on an online platform. They printed and signed the alerts after action had been taken and retained them for future reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had crown-stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had a clean triangle used to count tablets and a separate clean capsule counter.

The pharmacy had cordless telephones so that conversations could be kept private. And it stored medicines awaiting collection in the dispensary in a way that ensured people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned in way that meant only authorised people could see the information on the screens.

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.