General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2C, Springfield Retail Park, Edgar Road, ELGIN, Morayshire, IV30 6WQ

Pharmacy reference: 1101294

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

This is a community pharmacy in a retail park on the edge of a town. People of all ages use the pharmacy and it is open extended hours seven days a week.The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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 team members follow processes for all services to ensure that they are safe. They record some mistakes to learn from them and know that reviewing these helps to reduce incidents. The pharmacy keeps most records as it should by law. But some records are incomplete. This does not affect people using the pharmacy. The pharmacy keeps people's information safe and pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place which team members mostly followed for all activities/tasks. Sometimes team members did not use pharmacy information forms and initial prescriptions as per the SOP. They had all read and signed them. The SOPs were reviewed every two years and were signed off by the pharmacy superintendent. Staff roles and responsibilities were recorded on individual SOPs.

The team members described high risk activities such as visibility of the dispensary to the public, and sometimes staff shortages. They managed these by giving increased waiting times when necessary, prioritising activities and people, encouraging people to stand back from the dispensary and being as careful as they could with data in the dispensary. There was information on the dispensary wall to help team members managed risk and prioritise work. This included information about meeting professional and premises standards and arranging workload to conform with the company model day. Although this had not been updated for two months.

Dispensing, a high-risk activity, was observed to be smooth and logical with coloured baskets in use for separate people's prescriptions and medicines and prioritise urgent and waiting prescriptions. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels.

The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services. Contact details for other pharmacies and healthcare professionals. Each team member had their own near miss log to record errors identified in the pharmacy. No incidents had been recorded in the current month, and one person had two errors recorded the previous month. The locum pharmacist who had worked for three days in the pharmacy commented that he had not seen any errors. The pharmacy team members present during the inspection could not provide examples of changes made following incidents and were not aware of reviews being undertaken. But due to the pharmacy been busy, it was difficult to discuss this with the team. And the safer care champion was on annual leave and team members did not know where she kept her information or data.

Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

The pharmacy had a complaints procedure in place. The pharmacy had indemnity insurance certificate was in place, expiring end June 2019.

The pharmacy kept the following records: Responsible Pharmacist notice displayed; responsible

pharmacist log. This was incomplete with some missing sign out times. There were also very few pharmacists signing in from 7.30am to allow dispensing activities to take place using 'absence'. There were private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs registers, with running balances maintained and regularly audited; controlled drug (CD) destruction register for patient returned medicines; and
the electronic patient medication record was backed up each night to ensure data was not lost

Team members were aware of the need for confidentiality. They undertook annual training on the topic. Confidential waste was segregated for secure destruction. Team members were as careful as they could be when dispensing in front of patients, but no other people could see any confidential information.

Team members demonstrated awareness of safeguarding issues and undertook annual training. They had local child protection information and process on the dispensary wall. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy does not always have enough staff members to provide its services quickly. And sometimes team members are carrying out activities without a pharmacist. This does not affect people as the pharmacy is closed. The pharmacy team members have access to training material to ensure they have the skills they need. The pharmacy sometimes gives them time to do this training. And sometimes team members do it at home. The pharmacy team discuss incidents and information shared from head office to learn from them and avoid the same thing happening here.

Inspector's evidence

Staff numbers included: one full-time pharmacist, on annual leave at the time of inspection; one part-time pharmacist, on maternity leave at the time of inspection; one full-time preregistration pharmacist, on study leave at the time of inspection; one full-time trainee pharmacy technician, on annual leave at time of inspection; three full-time dispensers; three part-time dispensers; three assistant managers, one full-time and two part-time. One was a dispenser and two were undertaking dispensing training. There were also delivery drivers.

There was a shortage of relief pharmacists in the area so covering pharmacy hours was challenging. At the time of inspection, a locum pharmacist from England was working. Typically, the pharmacy had a pharmacist working from 8:30am to 5pm and one working from 11:30am to 8pm, providing double cover for part of the day. But due to shortages recently this was not often possible. A pharmacy team member explained that one day per week was staffed by pharmacists in this manner and sometimes a second day. And, typically, dispensers worked the following pattern, following a ‘model day’ to ensure all activities were addressed: one dispenser, 7.30am to 4pm; one or two dispensers, 8.30am to 6pm; one dispenser, 11.30am to 8pm. This meant there were two or three dispensers for most of the day and one dispenser and a pharmacist between 6 to 8pm which team members described as challenging. There were two team members on Friday evenings when it was busier. A dispenser worked alone between 7.30am to 8.30am with a responsible pharmacist supposed to be signed in and using absence. As noted elsewhere, pharmacists were often not signed in. Following the inspection, the store manager explained to the inspector that this had ceased. There were now strategies in place to ensure that no pharmacy activities took place without a responsible pharmacist signed in.

The inspection took place from 4:30pm to 8pm on a Tuesday, when there would usually be a pharmacist and two dispensers until 6pm, then one dispenser until 8pm. There was a locum pharmacist from England, a full-time dispenser and an assistant manager who remained in the pharmacy area for the duration to try and assist during the inspection. She would normally be undertaking other duties. The locum pharmacist had worked in the pharmacy for the previous two days. Throughout the inspection there was a queue of people waiting to be served at the medicines counter and dispensary. The inspector observed some people walking away from the medicines counter. This made it difficult for team members to speak to the inspector. The inspector was kept waiting for seven minutes in a queue, and this was what people were experiencing during the inspection. Team members present were under pressure and looked stressed. But they were managing the workload to the best of their ability and were polite and apologetic to people. People waiting were mostly patient and not complaining. A team member who should have worked until 6pm that day was unexpectedly absent.

Team members described staffing issues that day – a dispenser had started work at 7.30am. At 8.30am there was no pharmacist, so the pharmacy was shut (the rest of the store was open) until 10am when a pharmacist from another town arrived. He had to leave before 11am. The locum pharmacist started at 11am. He was due to have started at 11.30am but had been contacted and asked to start earlier. The RP log showed the times there had been no pharmacist that day i.e. 7.30 to 10am, and one minute before 11am. The dispenser working between 7.30 and 8.30am had undertaken activities that required a responsible pharmacist to be signed in. Team members explained that Monday to Friday a dispenser always worked between 7.30 to 8.30am, mainly managing DSP (dispensing support pharmacy) prescriptions. The RP log showed many days over recent months when there was no pharmacist signed in for this hour each day. The pharmacy was breaching legislation. The inspector observed this from November 2018, seven months previously.

The pharmacy team members described difficulties over the past few days with the regular pharmacist and pharmacy technician on annual leave, meaning that some tasks were not done. These included updating documents in the dispensary used as aide memoirs to support the team completing tasks on time and sharing timescales with patients. They were two days out of date, so there was a chance of patients being given the incorrect date to collect their medicines. If people came to the pharmacy early, time was wasted looking for prescriptions/dispensed medicines and explaining and apologising to people that they were not ready.

The pharmacy had weekly, and daily activities listed on the dispensary wall e.g. pouring methadone, ordering stock, putting stock away and dispensing at the front of the dispensary patient facing. Team members who were dispensing were encouraged to call colleagues for help as required.

The pharmacy provided protected learning time for electronic training modules, such as health and safety, confidentiality and safeguarding. All team members undertook these annually. They were also given time for other electronic modules when these were available and reading new standard operating procedures (SOPs). They undertook other training such as ’30-minute tutors’ in their own time at home. The pharmacy did not provide protected time for team members undertaking accredited training courses, and this was usually done at home. The pharmacy gave the preregistration pharmacist a half day per week for her training, which was done offsite, or in an office in the pharmacy.

Team members had annual performance development meetings and quarterly interim meetings with their manager. They each had a performance development plan with objectives related to targets and e.g. managing the queue on the medicines counter better as there were no medicines counter assistants.

Team members present during the inspection described an openness between all team members who were comfortable owning up to their own mistakes and discussing with each other. Pharmacy superintendent’s office shared information from across the organisation including case studies for discussion and reflection. Recent issues of the ‘Professional Standard’ were observed. One issue had a case study about the implication of dispensing incidents. A dispenser described this as useful and helped her to think about the bigger picture. These had been signed by some but not all team members.

The manager or assistant manager provided weekly briefing information which was displayed in the dispensary. The most recent one, dated two weeks before the inspection, has no pharmacy-related topics other than information regarding signing up to services. There was also other information regarding targets, loyalty and business.

The pharmacy set targets for various parameters. The scorecard was displayed in the dispensary to monitor progress. Team members commented that there was constant pressure to achieve targets but did not describe this negatively impacting on people. A ‘growth plan’ was displayed in the dispensary, with an action plan for increasing prescription items and people signed up to the text messaging service and reducing owings. There had been recent pressure targeting a large number of people whose medicines were being dispensed by the DSP. The pharmacy team had to describe this and obtain consent from every person affected. This had been time consuming, impacting work flow over recent months. This was now improving, and time was freed up in the pharmacuy due to an increasing volume of offsite dispensing. There was no clinical or accuracy information such as near miss reviews observed in the dispensary. The manager later explained that this was usually displayed on the dispensary wall.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. But the area where medicines are made up is small. And sometimes people can see what medicines other people are getting. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

These were large premises with a galley style dispensary and three fast track dispensing stations. The pharmacy had put up a screen on one of the stations to reduce distractions and provide some additional protection for confidential items. The pharmacist's checking bench was at the rear of the dispensary and the pharmacist stood with his back facing the public. This reduced distractions to enable concentration. Some areas of the dispensary were cramped and untidy, and there was a lack of storage. There were piles of papers/mail on dispensing benches, and some in document holders. Some mail, e.g. industry magazines had not been opened. 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. Team members were discreet but there was a constant queue of around seven people. And they could see what medicines were being taken off shelves and dispensed for the people waiting.

The premises were observed to be clean, hygienic and well maintained.

The pharmacy stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other patients or customers. But these drawers were very full. None of the dispensed medicines had been there for more than a few weeks, as per the SOP (other than one CMS prescription).

The pharmacy had a consultation room with a desk and chairs, which was clean and tidy, and the door closed providing privacy. There was a separate discreet area close to the consultation room, with a hatch to the dispensary for substance misuse supervision. People were taken to the consultation room for medicine supervision during the inspection.

The pharmacy was alarmed and had CCTV. It had shutters to protect the front door and windows when the pharmacy was closed. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to make sure they can all use its services. The pharmacy team mostly provides safe services. Some people get their medicines supplied in packs that help them take their medicine. The pharmacy sometimes makes these up on the day it is supplying them. Team members are rushing so might make mistakes. They do not always record enough information and they give some people four packs at a time when prescriptions only ask for one. Pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

There was good physical access by means of a flat entrance and an automatic door. The pharmacy displayed its services and had leaflets on a range of topics available. It kept a hearing loop in the consultation room which could be used with hearing aid users. All team members wore badges showing their name and role.

Dispensing work flow was logical with team members using baskets to separate people's medicines and prescriptions. They undertook most dispensing on forward facing dispensing benches which were subject to some interruption. The pharmacist checked prescriptions on a bench to the rear to avoid such distraction. Team members did not always share information with the pharmacist and did not routinely used pharmacist information forms (PIFs). They sometimes used labels to highlight high-risk items or those requiring special storage. Dispensed medicines received that morning from the dispensing support pharmacy (DSP) had not been put onto shelves.

Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. Additionally, initials of personnel involved at all stages of dispensing and supply were captured on prescriptions. But team members were not all doing this consistently. Owings were usually assembled later the same day, or the following day and a documented owing system was used.

The pharmacy provided a delivery service and drivers obtained signatures from people on receipt of their medicines. They got additional signatures for delivery of controlled drugs.

Multi-compartment compliance packs were managed on a four-weekly cycle with four assembled at a time. Team members used a tracker template to record progress of these, but it was not up-to-date. They labelled completed packs with patient information, date of supply and instalment number. And put tablet descriptions on packs. Patient information leaflets (PILs) were supplied with the first pack of each prescription. The pharmacy provided four packs at a time to some people although prescriptions stated, 'dispense weekly'. At the time of inspection packs were being checked for supply today. Team members explained that they were behind with this dispensing. Typically, they would be completed at the start of week for the following week to minimise pressure and risk.

The pharmacy kept records for all patients receiving multi-compartmental compliance packs, but these were variable in detail. Some were marked with day of supply, whether supply was delivery or collection, and whether one or four packs were supplied at a time. The pharmacy had not included this

detail for several people, so there could be confusion and risk. The pharmacy did not always record additional information either. The inspector observed some confusion e.g. one patient should receive their pack on Thursdays, but the day of inspection was a Tuesday and the current week's pack was not there. A team member knew this had been supplied early to cover holidays, but there was no documentation to this effect. A note regarding a change had been written on a scrap of paper for another patient. There was no date, prescriber name or pharmacy team member name. There were two packs in the pharmacy for this patient – week two, (16.06), and week three, (23.06). Packs for weeks one and four were not found. (18.06). This suggested that the pharmacy had supplied week four, (30.06) rather than the pack for week two. This would be confusing for the patient, carers and anyone else involved in his care such as a hospital admission.

A dispenser poured methadone instalments weekly on Sundays, a pharmacist checked them, then they were stored with prescriptions, alphabetically and tidily in controlled drug cabinets. Some labels were confusing, showing all the instructions as per the prescription e.g. '33ml daily. Dispense 132ml on Thursday and 99ml on Monday. Supervise daily dose on day of collection'. The locum pharmacist used the consultation room for supervision rather than the hatch to the dispensary, as the dispensary was busy. He asked each person for their name, address and expected dose. The pharmacy kept relevant information in a folder with patient treatment agreements. This included the local NHS information, and NHS Scotland best practice.

The pharmacy supplied a variety of other medicines by instalment. A team member generated all labels when prescriptions were received. They dispensed the instalments as people came to the pharmacy to collect them. Pharmacists undertook clinical checks and provided additional information to people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling.

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 chloramphenicol ophthalmic products. The pharmacy provided medicines to a lot of people on chronic medication service (CMS) prescriptions. Team members dispensed these prior to people coming to the pharmacy. They did not have a process in place to monitor compliance. One person's medicine (antidepressant) was observed on retrieval shelves with the record stating that it had been collected on 2 February 2019, and the next date due 19 March 2019. The pharmacy had not contacted the patient or the prescriber (18 June 2019).

Team members were empowered to deliver the minor ailments service (eMAS) within their competence. A few team members were trained to deliver the smoking cessation service – no detail about this service was available at the time of inspection.

The pharmacy obtained medicines from licensed suppliers such as Alliance. It stored medicines in original packaging on shelves/in drawers and cupboards. And it kept items requiring cold storage in a fridge. Team members monitored minimum and maximum temperatures and took appropriate action if there was any deviation from accepted limits. They stored non-controlled drug items required for the palliative care service in a labelled drawer. The pharmacy team members regularly checked expiry dates of medicines, but one item was observed that had expired 14 months previously. The pharmacy did not comply with the requirements of the Falsified Medicines Directive (FMD). It 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 been supplied with medicines affected by 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.

It kept a carbon monoxide monitor which was maintained by the health board, and a blood pressure meter which was replaced annually, in the consultation room where they were used with people accessing pharmacy services.

The pharmacy had a range of BS stamped with separate marked ones used for methadone. These were cleaned after each use. And it had clean tablet and capsule counters including a separate marked one for cytotoxic tablets.

Archived paper records were stored in a locked filing cabinet in the office, and other records were stored in the dispensary inaccessible to the public.

Team members never left computers unattended and they used passwords. They protected computer screens to ensure they were not visible to the public.

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.