General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 71 Lothian Crescent, DUNDEE, DD4 0HU

Pharmacy reference: 1121585

Type of pharmacy: Community

Date of inspection: 01/08/2019

Pharmacy context

This is a community pharmacy in a modern purpose-built development. It includes a GP practice, dental services, social work, podiatry, child services and a café. People of all ages use the pharmacy. 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

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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 mistake happening again. The pharmacy welcomes feedback and team members act on this to improve pharmacy services. The pharmacy keeps all the records that it needs to and 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/tasks. They were reviewed and signed off by the pharmacy superintendent every two years. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy had recently received new core SOPs and team members were in the process of reading these and undertaking a quiz to test their understanding before they were signed 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. A trainee dispenser was clear about the scope of her role and described activities that she was not yet fully competent in. She explained that she would only undertake these under supervision of a colleague. The pharmacy technician had additional responsibilities for tasks including pharmacy paperwork and stock control. Dispensing, a high-risk activity, was well managed and organised with baskets in use for dispensing to separate people's prescriptions and medicines. The pharmacy team managed the workload to avoid routine activities being undertaken during busy dispensing times. Team members assembled multi-compartmental compliance packs and assembled instalment prescriptions in mornings before the collection service prescriptions were received from the GP practices. The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services. It had an emergency cascade accessible by the phone in the dispensary to share urgent information with other pharmacies.

The pharmacy kept near miss logs and had an error reporting framework in place. The pharmacist reviewed near miss errors and errors reaching patients each month to identify any trends, patterns or training needs. She created an action plan based on this which was discussed with all team members. Recently they had discussed strategies to minimise distractions and being pulled away from dispensing. This had resulted in team members giving longer waiting times to people for walk-in prescriptions. This gave them more time to concentrate on dispensing. People always waited for prescriptions as there was nothing to do close to the pharmacy e.g. there were no shops. A few months previously incorrect strengths had been identified – this was discussed and monitored and showed an improvement. The previous month incorrect forms had featured, and this was discussed among the team with reminders to read prescriptions carefully and not make assumptions. The pharmacist was coaching the pharmacy technician to undertake these monthly reviews.

The pharmacy had a complaints procedure in place and team members described welcoming feedback. One team member explained that she was not local and did not have a local accent. Sometimes people found her difficult to understand. She had received feedback about this especially on phone calls. She described trying to speak slowly and clearly and depending on response, repeating what she had said. She explained that this took patience.

The pharmacy had Indemnity insurance in place, expiring 30 June 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. The pharmacist initialled alterations to records and these were clearly annotated. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Team members were aware of the need for confidentiality. They undertook annual training and had read and signed company procedures. They segregated confidential waste for secure destruction and no person identifiable information was visible to the public. Team members also undertook annual training on safeguarding. A trainee described having done this twice in the past few months as she had done it when she started employment and again when all staff were required to do it as an annual refresher. The pharmacy had local information and the process to be followed including contact details readily accessible in the staff room. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members to safely provide its services. The pharmacy compares staff numbers to how busy the pharmacy is and makes changes when it can. Team members have access to training material to ensure they have the skills they need. The pharmacy usually gives them time to do this training. Team members can share information, make suggestions and raise concerns to keep the pharmacy safe. The pharmacy team discusses incidents. Team members learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, with a half day per fortnight double cover; one full-time pharmacy technician; one full-time and one part-time dispensers and one full-time trainee pharmacy advisor (medicines counter and dispensary assistant); one Saturday only pharmacy advisor. The part-time dispenser worked mornings Monday to Friday. The Saturday only team member worked alone with the pharmacist on Saturdays. She was competent as she had previously worked several days per week in this pharmacy and in another busy branch locally. The pharmacist manager had started in this pharmacy five months previously.

The pharmacy displayed certificates of qualification. Team members could manage the workload and the pharmacy used rotas to highlight any gaps during holidays and absence. This enabled all team members to know who was working when and to ensure that there was maximum staffing at busy periods. There was a school cross the road from the pharmacy and the pharmacy could become busy at school start and end times. There were usually four team members in mornings and three in afternoons. Routine planned tasks such as instalment dispensing were undertaken in mornings when there were more team members working.

The pharmacy provided some protected learning time for all team members to read new SOPs and undertake regular company training such as ‘30-minute tutors’ and e-learning modules. Team members described doing some of these in their own time at home as they had more time and concentrate better in that environment. The trainee pharmacy advisor had one hour per week protected time at work for her course. The pharmacy technician was undertaking accuracy checking training and was doing most of her coursework at home. The pharmacist was supervising them on the job and colleagues were available for answering questions. On-the-job coaching and supervision were observed. All team members had six monthly development meetings and development plans in place. They described meetings as helpful to identify and address their learning needs. The pharmacy technician had objectives related to supporting other team members including the new pharmacist manager, completing her accuracy checking course and developing services. The pharmacist’s objectives were related to her own management development, learning all aspects of the business and increasing pharmacy services. Team members were observed going about their tasks in a systematic and professional manner. They managed over-the-counter requests well, using the sale of medicines protocol, and referring to the pharmacist appropriately. They demonstrated awareness of frequent requests for short-term use medicines.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could

share and discuss these. They explained that they could raise concerns and offer opinion to the manager or the area manager. The pharmacy had a whistleblowing policy that team members knew about. Team members described discussing any potential changes so that they were satisfied that changes were to improve services and not for the sake of change. The pharmacy superintendent sent regular updates and information from across the organisation. Much of this was contained in the 'professional standard' document which all team members read and signed. The pharmacist explained that this was also used to discuss incidents. The recent edition was in the dispensary for all to access. The pharmacy set targets for various parameters and they were usually met. The pharmacist explained that they were used positively to help patients and services were only offered to people who would benefit. The pharmacy was becoming busier with new houses being built in the area which contributed to increased footfall.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. 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

The premises were situated in a modern building incorporating a GP practice, community centre, library, social services, child services and a cafe. They were clean, hygienic and well maintained. There were staff facilities and some storage in the back-shop area. Storage space was limited so some sundries such as bags were stored in the staff toilet area. The dispensary was adequately sized with public facing dispensing stations including one that was discreet and provided some privacy. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. The pharmacy had a hatch to the dispensary which was located at the back of the retail area in a discreet area. This was used for delivery of substance misuse services including supervised self-administration of medicines. Team members ensured there was no person identifiable information visible in this area of the dispensary.

The pharmacy had a consultation room with a desk, chairs and sink which was clean and tidy and the door closed providing privacy. The door was kept locked to prevent unauthorised access. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

Temperature and lighting were comfortable on the shop floor and dispensary. But it felt too hot in the back-shop area. On the day of inspection, it was too hot for team members to remain in the area for rest breaks. The air condition unit was here, as it was not allowed to be fixed externally to the building. The pharmacist planned to monitor this because medicines and baby food were stored in this area. They should not normally be stored above 25C.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides 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 properly. The pharmacy team know 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 automatic door. It displayed a list of its services and had leaflets on a variety of topics. It had a hearing loop in working order to help people who used hearing aids. A team member explained that there were several patients with impaired hearing who lip read so they ensured that they faced these people and talked slowly and clearly. The pharmacy could provide large print labels and separate instruction sheets for people with impaired vision – one person was using this strategy. The pharmacy provided a delivery service although there were very few deliveries required. People signed to acknowledge receipt of their medicines. All team members wore badges showing their name and role.

Team members followed a logical and methodical workflow for dispensing. The pharmacy had two patient facing workstations, one was more discreet. Team members used the front one for walk-in prescriptions and people were asked to stand back to avoid personal data being seen. Prescriptions were received from the GP practice twice a day and these were labelled and dispensed at the other workstation and sometimes further back in the dispensary depending on how many dispensers were working. Throughout the day there was one dispenser on the walk-in area and at least one in the other area. The pharmacist checked prescriptions at the front workstation and within the dispensary on a dedicated checking bench. Dispensers used pharmacist information forms with all prescriptions to share information with pharmacist including new items or the date of previous supplies to support and facilitate the clinical assessment. They also used cards to highlight additional information such as high-risk items or special storage required e.g. fridge or CD cabinet. Team members initialled dispensing labels and prescriptions to provide a complete audit of who had been involved at all stages of the assembly and handout dispensed medicines. The pharmacy usually assembled owings later the same day or the following day and a documented owing system was in place. The part-time dispenser managed and assembled multi-compartmental compliance packs and instalment dispensing including methadone. She undertook these activities each morning, aiming to get as much done as possible before the prescriptions were received from the GP practice. Multi-compartmental compliance packs were managed on a four-weekly cycle with four assembled at a time. They were done at least a week ahead of the first pack going out. At the time of inspection, they were two weeks ahead to cover planned annual leave. Instalment number and date of supply were on each medicine label and on the pack itself. Tablet descriptions were also on labels. The pharmacy supplied patient information leaflets with the first supply of each prescription. People signed to acknowledge receipt of these packs which enabled the pharmacy to monitor compliance. The pharmacy supplied a variety of medicines to people by weekly and daily instalments. Team members dispensed these monthly and they were placed in labelled bags in patient named boxes close to the standard retrieval area. They kept records of dispensing and supply for a few months then disposed of these and confidential waste. Some people received medicines from chronic medication service (CMS) serial prescriptions. Team members

dispensed these and sent text messages to people prior to the expected due date. They kept records of dispensing and supply to monitor compliance. There was no evidence of poor compliance, but a few examples were described of contacting the GP practice when patients had not collected medicines as expected. The pharmacy signed patients up to the service. but no pharmaceutical care issues were described.

The pharmacist undertook clinical checks and advised and counselled people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin. She provided written information and record books if required. The valproate pregnancy prevention programme was in place – this had been implemented including a search for people in the 'at risk' group before the pharmacist was in this branch. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell. 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, chloramphenicol ophthalmic products and paracetamol post immunisation. Team members were empowered to deliver the minor ailments service (eMAS) within their competence. The trainee pharmacy adviser described asking colleagues for help and all team members referred appropriately to the pharmacist.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacist and some other team members were aware of this but had not had any training yet and there was no equipment on the premises. 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 action taken 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. The pharmacy protects people's privacy.

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 its services in the consultation room where it was used with patients accessing these services. This included a carbon monoxide monitor maintained by the health board. Team members kept Crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They had a pump available for methadone use and this was cleaned after each use. And test volumes were poured with each different amount set and these were checked by the pharmacist. This was observed during the inspection. The pump was calibrated just over a year ago and was planned to be done over the next few weeks. The pharmacist explained that the pump was measuring accurately. The pharmacy had clean tablet and capsule counters including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in a locked filing cabinet in the consultation room, which was kept locked. Team members used passwords to access computers, and never left them unattended. They took care to ensure phone conversations could not be overheard – they moved to the back of the dispensary.

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.