

Registered pharmacy inspection report

Pharmacy Name: Boots, 121-127 St. James Crescent, Edinburgh, EH1 3AD

Pharmacy reference: 9011563

Type of pharmacy: Community

Date of inspection: 03/02/2022

Pharmacy context

This is a community pharmacy which re-located into a shopping mall in June 2021. It dispenses NHS and private prescriptions. And it supplies some medicines in multi-compartment compliance packs. The pharmacy team advises on minor ailments and medicines' use through the NHS Pharmacy First service. The pharmacy supplies and sells a range of over-the-counter medicines and offers services including smoking cessation and seasonal flu vaccination. It is open extended hours, and seven days a week. This pharmacy was inspected during the COVID-19 pandemic.

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 suitably identifies and manages the risks associated with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records it needs to by law, and it keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

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 counters and tills throughout the store including the medicines' counter. And it had hand sanitiser available in several places for team members and people using the pharmacy to use. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room after use. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. Team members carried out Lateral flow Covid-19 tests twice weekly to enable them to isolate if they had Covid-19.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Team member roles and responsibilities were recorded on individual SOPs. They described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to keep a person's medicines together with the corresponding prescriptions. 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, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They used these records to complete monthly patient safety reviews to learn from errors. And they introduced strategies to minimise the chances of the same error happening again. Recently team members had been reminded to score open packets on all surfaces to reduce the chance of supplying the wrong quantity of tablets. And the pharmacy had introduced better hand-over briefings to locum pharmacists to ensure that they were aware of any issues to be dealt with or to be followed up. The pharmacy had a complaints procedure and welcomed feedback. Team members did not describe any complaints. And the pharmacy displayed feedback from service users on a staff notice board. This was observed to be mainly positive.

The pharmacy had indemnity insurance expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and

regularly audited. Balances checked were correct. It had a CD destruction register for patient returned medicines. During the inspection a dentist returned an obsolete schedule 3 controlled drug and requested a replacement. But the request was not on the appropriate requisition form. The inspector confirmed the requirement with the pharmacist following the inspection. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. 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 undertaken training. 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 registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. It supports team members by providing time for training during the working day. Team members make decisions within their competence to provide safe services to people. And they use their professional judgement well to help people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had one full-time pharmacist, two full-time and one part-time qualified healthcare advisors and one full-time and one part-time trainee healthcare advisors. Additionally, the full-time manager was undertaking training and was competent on the medicines' counter. The pharmacy also had two full-time and one part-time assistant managers, one of whom was a qualified healthcare advisor and the other two were undertaking training. The pharmacist worked from 9am – 8pm, three or four days per week. Locum pharmacists worked the other days. Typically, there were two team members and a pharmacist working at the busier times of day, from 11am – 5.30pm. And one team member and a pharmacist at the start and end of the day. Team members described this as adequate. But at the time of inspection the pharmacist was alone until 11.30 due to annual leave. But a qualified assistant manager supported him during the inspection. She was aware that he was alone and was monitoring how busy the pharmacy area was. The pharmacy also had 15 team members working a variety of hours and work patterns in the non-pharmacy retail area. The pharmacy reviewed staffing levels regularly. The manager explained that she expected business to grow as there were a lot of offices near the pharmacy. As Covid restrictions were easing, office workers were gradually returning to work which was likely to impact the pharmacy's workload. The pharmacy used rotas to manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. A few months previously there had been challenges across the store as several team members had left at the same time. The pharmacy had successfully filled the vacancies, but there had been a period when there were a limited number of trained team members available.

The pharmacy provided weekly learning time during the working day for all team members to undertake regular training and development. This included accessing online modules and reading SOPs and other company communications such as the 'Professional Standard'. And the pharmacy provided team members undertaking accredited courses with additional time to complete coursework. The pharmacist supervised trainee team members. 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 an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy empowered team members to deliver services such as Pharmacy First autonomously within their competence.

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 could make suggestions and raise concerns to the manager or area manager. And team members including a manager and a pharmacist gave appropriate responses to scenarios posed. The pharmacy superintendent shared information and incidents from elsewhere in the

organisation for all team members to learn from incidents. Team members read this document and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The team did not have formal structured meetings, but shared information continually 'on the job'. The pharmacy was not busy currently, and team members worked different hours, so this approach worked well. They also had a social media group chat which they described as useful to share general information, ensuring they all received it. And they used a communications book in the dispensary. This was observed to be in constant use and included detailed information. It was invaluable for continuity of care due to the extended working hours and the variety of pharmacists working. The pharmacy had notice boards in staff areas sharing information and encouraging non-pharmacy team members to take advantage of the pharmacy services such as flu vaccination. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described how they used these in a positive way to offer services to people who would benefit.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean and suitable for the pharmacy services provided. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed. Pharmacy team members report any maintenance issues, and the pharmacy addresses these appropriately.

Inspector's evidence

These were large premises incorporating a large retail area selling a variety of toiletries and cosmetics, a dispensary and back shop area including storage space and staff facilities. The staff room had cleaning materials and plastic partitions on tables as part of the store's infection control measures. The storage areas were observed to be congested although tidy. The premises were clean, hygienic, and well maintained. Team members cleaned surfaces and touch points regularly throughout the day. And contract cleaners cleaned floors and all areas several times a week. Due to staffing issues, they had recently been unable to clean customer toilets, so the pharmacy was not offering this facility. There were public toilets close by in the shopping mall, so this was not a problem. There were sinks in the dispensary, staff room and toilets. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available throughout the premises for team members and people using the pharmacy. During the inspection a maintenance issue was raised and was to be resolved over the next few days.

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 providing privacy. The flooring was of clinical standard. This room was large enough for social distancing. The door was kept locked to prevent unauthorised access. Temperature and lighting felt comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access with car parking and a level entrance into the shopping mall and store. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as sexual health services and travel vaccinations. And team members had access to resources and references that they could use themselves or refer people to, for example from Macmillan Cancer Care. The pharmacy 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. All team members wore badges showing their name and role.

Pharmacy team members followed a logical and methodical workflow for dispensing using slightly different but defined processes depending on the prescription type, for example managed repeat prescriptions, serial prescriptions, or 'walk-in' prescriptions. This enabled team members to prioritise dispensing and checking of medicines for immediate supply. They used baskets to separate people's medicines and prescriptions. The computer labelling system generated pharmacist information forms (PIFs) highlighting information including new medicines or changed doses. The dispensers also added handwritten notes as relevant, and attached cards to prescriptions highlighting high-risk medication, fridge lines and controlled drugs. This helped the pharmacist to carry out clinical checks on all prescriptions. 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. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these before the agreed date of supply and the pharmacy sent the person a text message informing them their medicine was ready for collection. The pharmacy kept records of these supplies and updated the NHS system to ensure the person's emergency care summary was accurate. The pharmacist carried out pharmaceutical care needs' assessments within three months of registration, as required by the service specification. He had not identified pharmaceutical care issues. This was possibly because often practice pharmacists had already discussed people's medicines with them when the serial prescription had started. This service was being driven locally by practice pharmacists working with community pharmacists.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. Team members included tablet descriptions on labels, and they provided patient information leaflets with the first pack of each prescription. And they labelled the packs with the person's details and date of supply. They kept robust

records of changes and other relevant information in chronological order which helped locum pharmacists provide the service. The pharmacy stored these packs in individually labelled box files on a shelf in the dispensary.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They or a team member supplied written information and record books if required. The pharmacy had information on the dispensary wall about high-risk medicines for team members to refer to. It had put the guidance from the valproate pregnancy prevention programme in place, and team members followed the service specifications for NHS services. The pharmacy had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. It also followed private PGDs for flu vaccinations. 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. And they referred to the pharmacist as required, using a consultation form to share information with the pharmacist, and to ensure the correct information was added to the person's medication record. Due to the extended hours that the pharmacy was open, it sometimes supplied medicines under the unscheduled care service. Team members were aware of it and pharmacists had signed the PGD for this health board area. The pharmacy was in the city centre, so often had requests for medicines from people who were not registered with a GP in Scotland which meant that they were unable to access services such as Pharmacy First or unscheduled care. Team members signposted some people to local GPs for temporary residents' registration. And they also signposted to the Boots online prescribing service. They provided people with a card about this service which included the website and a QR code which they could scan. The pharmacy offered private and NHS flu vaccination during the season and was still providing occasional vaccinations. The smoking cessation service was currently quiet. The pharmacy also had a hearing care service, but pharmacy team members were not involved with it. The pharmacist explained that the practitioner had been recruited through head office who had confirmed their credentials.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, Phoenix and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. They had labelled fridge shelves to separate flu vaccines for different age groups. 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 and the Boots Healthcare Way when selling these. A team member provided exemplary responses when the inspector posed scenarios regarding medicines' sales.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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. It looks after this equipment to ensure it works.

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 online resources to be used.

The pharmacy had equipment it required to deliver its services. This included a carbon monoxide monitor maintained by the health board which was used with people accessing the smoking cessation service, items required for flu vaccination, a range of clean crown-stamped measures and tablet counters. It had a separate tablet counter for cytotoxic tablets.

The pharmacy stored paper records in a locked filing cabinet 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 patient 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.