General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 5 Burns Precinct, KILMARNOCK, Ayrshire, KA1 1LT

Pharmacy reference: 1041843

Type of pharmacy: Community

Date of inspection: 19/09/2024

Pharmacy context

This is a community pharmacy in a small shopping precinct in the town of Kilmarnock, Ayrshire. Its main activity is dispensing NHS prescriptions. It provides a range of NHS services including Pharmacy First and Pharmacy First Plus. It provides some people with their medicines in multi-compartment compliance packs. And it has a delivery service, taking medicines to people in their homes.

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's written procedures help team members to manage risk to provide services safely. Team members record mistakes made during the dispensing process and review them to identify learnings to help prevent the same or a similar mistake from occurring. They mostly keep the records required by law and keep people's private information secure. They have the necessary training and understanding to respond effectively to concerns for the welfare of people accessing the pharmacy's services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help team members to work safely and effectively. These were reviewed by the company's superintendent pharmacist (SI) team every two years. And team members were directed to complete 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. All team members had completed the most recently updated SOPs. The pharmacist was an independent prescriber (PIP) who provided the NHS Pharmacy First Plus service. They had completed a scope of practice document which covered the conditions for which they prescribed, training they had undertaken and processes to follow if a person was unable to be treated under the service. The scope of practice was reviewed and approved by a prescriber at the company's head office team.

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, and if they were not present, the person who identified the error captured the details about it. And the team member was made aware of the mistakes made when a monthly review of the data was completed. A review for August showed that quantity errors were common. And team members had highlighted a problem with prescriptions for inhalers as the quantity did not always transfer from the prescription to the computer system correctly. Their learning was to be more vigilant to this occurring, to help prevent mistakes. Team members had also separated higher risk medicines such as quetiapine, methotrexate and gliclazide in the dispensary from other medicines to highlight that extra caution was required when selecting these medicines. The pharmacy completed incident reports for errors that were not identified until after a person had received their medicine. These were recorded electronically and investigated and resolved by the pharmacy manager. And if necessary, the reports were shared with the area manager. Learnings from dispensing errors were captured and had included improving team communication and reviewing relevant SOPs. The pharmacy had a process for dealing with complaints or concerns. Team members aimed to resolve any complaints informally in the first instance and if they were unable to, they could be escalated to the area manager or company's customer care team. The pharmacy generally received positive feedback from people, and this was observed during the inspection. Team members had received complaints about the speed of service and were observed being proactive to serve people as they arrived.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. The pharmacy manager had recently completed a roles and responsibility matrix which detailed which team members were able to complete which tasks. The pharmacy had two accuracy checking pharmacy technicians (ACPTs). One of the ACPTs was experienced

and felt comfortable to check all prescriptions. The second was newly employed and was in the process of having their items double checked by the pharmacists before being able to check independently. The ACPTs knew which items could be accuracy checked as the pharmacist had signed the prescription to confirm a clinical check had taken place. 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 details of the RP. 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 in order, with some minor omissions of the wholesaler address 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 destroyed and witnessed by two team members, at least one of whom was a registrant. Patient returned medicines were kept separately from routine stock medicines, so they did not become mixed up. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials”. And details of who the medicine was supplied to provided an audit trail in the event of any queries. It kept complete electronic records for its supply of medicines against private prescriptions and retained the associated prescriptions.

The pharmacy had both company and NHS data processing notices displayed 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. It displayed a chaperone policy in the retail area informing people of their right to have a chaperone present for consultations that took place in the consultation room. Team members received annual training for safeguarding of vulnerable adults and children. They knew to refer any concerns to the pharmacists in the first instance, but they had not had to do so. The pharmacists knew the steps to take to refer any concerns to the relevant people. The pharmacists were registered with the Protecting Vulnerable Groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and competent team members to help manage the workload. Those who are in training receive appropriate supervision. The pharmacists complete ongoing training to help them with their practice. And other team members receive regular additional learning. Team members suitably respond to requests for advice and sales of medicines.

Inspector's evidence

The pharmacy employed a resident pharmacist who was the RP at the time of the inspection. They were supported by a second pharmacist during the inspection who worked two days a week in the pharmacy. The pharmacists were supported by an ACPT, two dispensers and a newly employed ACPT who was helping with dispensing activities. The pharmacy team further comprised of four dispensers and a trainee dispenser who were not present. Team members had either completed, or were in the process of completing, accredited training for their roles. The trainee dispenser's training was overseen by the resident pharmacist who acted as their tutor. And they had opportunities to review the training fortnightly when they worked alongside each other. The trainee dispenser received protected learning time to progress through their training in a timely manner. Team members received a monthly newsletter which provided information and learnings from other pharmacies in the company. The PIP provided the NHS Pharmacy First Plus service and had assessed their own competency and prescribed for only certain conditions, which were outlined in their scope of practice. They had completed training including about sepsis, and the use of diagnostic tools to be able to provide the service. And both pharmacists had completed training for the conditions treated under NHS Pharmacy First. The second pharmacist was completing the NHS Education for Scotland (NES) first year Foundation Training programme and received two supervised visits from a company pharmacist trainer per month. And they completed clinical study days provided by NES.

Team members were observed to work well together and were managing the workload. Annual leave was planned in advance and part-time team members or team members from other pharmacies in the company could support periods of absence. Some team members received performance reviews, and this had been completed by the pharmacist. For other team members they received feedback during the course of their work. There was an open and honest culture amongst the team, and they felt comfortable raising concerns if required. And the company had a whistleblowing policy for its team members if necessary.

Team members asked appropriate questions when selling medicines over the counter and were observed referring to the pharmacist for any queries. They were vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They gave examples of supportive conversations they had had with people to help them with their healthcare needs. The pharmacy set its team members targets and 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 it provides. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy was comprised of a spacious retail area and long dispensary with room for team members to move around freely. There was a medicines counter which was situated adjacent to the entrance to the dispensary. The dispensary had different work benches where team members completed different tasks. And some of the work benches were behind partitions to help minimise distractions. The pharmacist's checking area was situated centrally, so they were able to supervise the dispensary and medicines counter easily. The dispensary had a sink which provided hot and cold water and soap for hand washing. And toilet facilities were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a soundproofed room which allowed people to have private conversations and access services. There was a desk and chairs for the pharmacist and people to use. The room had a sink which provided hot and cold water. The pharmacy had a separate room next to the consultation room which was used to provide privacy for people who had their medicines supervised via a hatch in the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had level access from the shopping centre. Automatic doors helped provide ease of access to those using wheelchairs or with prams. Team members provided large print labels for those with visual difficulties and assisted people with hearing difficulties by providing information in writing. The pharmacy had access to translation services for people whose first language was not English. It displayed a range of healthcare leaflets for people to read or take away. And team members sign posted people to other pharmacies for access to service they did not offer.

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. Team members highlighted electronically the inclusion of a CD, fridge line or a higher risk medicine. And when they handed out higher risk medicines to people a hand-held electronic device prompted team members to ask questions to ensure they were taking their medicines safely. And it recorded that team members had asked the questions. Laminates were used to highlight that a medicine was for a child or if the pharmacist needed to speak to people before handing out the prescription. Team members were aware of the requirements of the Pregnancy Prevention Programme (PPP) and of the need to ensure people received the correct information to take their medicine effectively. They were aware of recently updated legislation for providing valproate in original manufacturers packs and had completed risk assessments for people who received their medicine out with the manufacturers original pack. And they confirmed they did not have anyone in the at-risk category. Team members were observed asking appropriate questions when handing out medicines to ensure they were provided to the correct person.

The pharmacy's NHS Pharmacy First service was underpinned by patient group directions (PGDs) which were up to date. The pharmacists were alerted via email to updated versions of the PGDs when they were issued. The PIP provided the NHS Pharmacy First Plus service. They recorded their consultations on the person's patient medication record (PMR) and sent the details of the consultation, including medication prescribed, to the person's GP. The pharmacist had access to people's emergency care summary which provided additional information about people's medical history. The pharmacy supervised the administration of medicine for some people. Team members managed the service by preparing the medicine on a weekly basis, so the medicine was ready for people to collect. The pharmacy provided some people with their medicine in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions in advance so any queries about a person's medication could be resolved. Each person had a medication record which detailed the medicines taken and administration times. Changes to a person's medication were communicated from the person's GP and a record of the change was kept with the persons medication record. Team members provided descriptions of the medicines in the pack so they could be easily

identified. And they provided patient information leaflets once a month, so people had the necessary information to take their medicines. The pharmacy provided a delivery service, taking medicines to people in their homes. Team members added the deliveries to an electronic platform and could highlight the inclusion of a fridge line or CD. The drivers asked people to sign to confirm the receipt of their deliveries. And any deliveries attempted when the person was not available to receive them were returned to the pharmacy.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which ensured sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. And records showed date checking was up to date. Team members highlighted medicines that were going out of date in the next six months for use first and they were removed a month before they were due to expire. Liquid medicines with a shortened expiry on opening were marked with the date of opening. The pharmacy had a fridge to store medicines that required cold storage. Team members recorded the temperatures daily with records showing the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls on a company platform. They printed off and signed them as a record that action had been taken and retained them for future use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to electronic access to Medicines Complete, which allowed access to resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). The pharmacist used National Institute for Clinical Excellence and Scottish Intercollegiate Guidelines Network guidelines to assist them with their prescribing decisions. They had equipment used for the NHS Pharmacy First Plus service including tongue depressors, an otoscope and blood pressure machine. The pharmacy had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had triangles for counting tablets. The pharmacy used a pump to measure doses of substance misuse medicines, which had been calibrated in June 2024 to confirm it measured accurate doses.

The pharmacy had cordless telephones so that conversations could be kept private. And it stored medicines awaiting collection within the dispensary in a way that prevented people's private information from being seen by unauthorised people. Confidential information was secured on computers used passwords. And screens were positioned in a way that ensured only authorised people could see them.

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.