General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 62-70 King Street, KILMARNOCK, Ayrshire, KA1 1PA

Pharmacy reference: 1041851

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

This is a community pharmacy on a main street in the town of Kilmarnock in Ayrshire. Its main activities are dispensing NHS prescriptions and providing medicines to people living in care homes. It provides a range of NHS services including NHS Pharmacy First Plus and NHS Pharmacy First. It provides a delivery service, taking medicines to people in their homes or in care 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 and risk assessments help team members deliver services safely. Team members record errors made during the dispensing process and take steps to help prevent them from occurring again. They keep the records required by law and they keep people’s private information secure. They have the necessary training to respond effectively to concerns about the welfare of vulnerable people accessing the pharmacy’s services.

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 pharmacist (SI) team every two years. Team members accessed them on an electronic platform where they were directed to review newly updated SOPs when they were released. They completed quizzes to confirm their understanding of them and compliance with completion was monitored by the pharmacy manager. An accuracy checking pharmacy technician (ACPT) present during the inspection was experienced and was comfortable checking all types of prescriptions. And they knew which prescriptions were able to have a final accuracy check completed as they had been signed by the pharmacists to confirm a clinical check was completed. The pharmacy provided the NHS Pharmacy First Plus service. The pharmacist independent prescriber (PIP) who provided the service had completed a prescribing risk assessment prior to providing the service. This included information to help mitigate risks associated with the service such as training they had completed, how they would communicate their consultations with the person’s GP and suitability of the consultation room.

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 electronically. The ACPTs completed a monthly patient safety report. This helped to identify areas where mistakes were commonly made, and documented action points taken to help prevent the same or a similar mistake from occurring again. ACPTs conducted briefings with team members to discuss the findings from the patient safety report. In the pharmacy’s main dispensary, team members had separated higher risk medicines such as quetiapine and gliclazide from other medicines on the shelves to alert team members to take extra caution when selecting these medicines. The pharmacy completed incident reports for errors that were identified after a person had received their medicine, known as dispensing errors. These were recorded electronically and were shared with the pharmacy manager, area manager or the SI pharmacist’s team as appropriate. The PIP had a process for auditing their prescribing activity and the company had a process whereby PIPs were required to have an annual review with a prescriber at the head office. However, the PIP had not yet taken part in these processes as they had been prescribing only six months at the time of the inspection. 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 in the first instance. Any concerns or complaints that could not be resolved, or were received via the company’s head office, were escalated to the pharmacy manager to resolve. Team members sought feedback from people accessing the pharmacy’s services in the form of surveys and feedback was shared with team members.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. They 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 but did not reflect the correct details of the RP on duty at the beginning of the inspection. This was highlighted and it was changed to reflect the correct RP. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs in a paper-based register. The records were completed correctly except for the address of supplying wholesaler which was generally not recorded. Team members completed checks of the stock held against the register running balance weekly. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. Returned medicines were stored separately so they were not mixed with routine stock medicines. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials”, and the details of who the medicines were supplied to which provided an audit trail. It kept a complete electronic record of the supply of medicines against private prescriptions. And it kept associated prescriptions.

The pharmacy displayed both company and NHS data privacy notices prominently 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 about safeguarding vulnerable adults and children. And there was a safeguarding policy for team members to refer to, including a flow chart and contact details for local safeguarding teams. Team members referred any concerns to the pharmacist. The pharmacists were registered with the protecting vulnerable groups (PVG) scheme. The pharmacy displayed a chaperone policy in the consultation room, informing people of their right to have a chaperone present during consultations.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team, who are suitably skilled and competent to provide its services. Team members in training are appropriately supervised to complete their training. Team members suitably respond to requests for advice and sales of medicines.

Inspector's evidence

At the time of the inspection, there were two locum pharmacists working. They were supported by six trained dispensers, one of whom was training to be a pharmacy technician and led the care home department, three trainee dispensers and an ACPT. In addition to this, the pharmacy employed a further four trained dispensers, two trainee dispensers, a pharmacy student, and two ACPTs. There were four pharmacists who covered the pharmacy's opening hours. Team members were observed to work well together and were managing the workload. In the pharmacy's main dispensary, team members had a daily rota which detailed what tasks were to be completed by who. And in the care home department, the care home lead dispenser planned who completed which tasks daily. Annual leave was planned in advance. Part-time team members could increase their hours to support periods of absence. And workload was assessed and prioritised to ensure continuity of service delivery during periods of absence.

Team members had either completed, or were in the process of completing, accredited training for their roles. Team members who wished to undertake additional qualifications to develop their skills and knowledge could raise this with management. Those in training were supervised by one of the regular pharmacists or technicians. Team members in training completed the majority of their coursework at home and had some opportunities to complete training in the pharmacy. And they had regular check ins with their tutors to discuss their progress or anything they needed help with. Team members received a monthly newsletter from the company which provided information and learnings from other pharmacies in the company. The pharmacist on duty in the main dispensary had completed training to provide the NHS Pharmacy First service and updated their learning as patient group directions (PGDs) were updated. A selection of PGDs seen in the dispensary were up to date and the regular pharmacists had signed declarations of competency to confirm they had read and understood the PGDs. The PIP assessed their own competency to prescribe for the NHS Pharmacy First Plus service and prescribed for common clinical conditions including sore throat and oral thrush. And they had completed clinical skills training and had recorded this training on their scope of practice. The PIP kept up to date with their clinical knowledge through company organised development days where they could have discussions with other PIPs in the company. And they used local and national guidelines including National Institute for Clinical Excellence (NICE) guidelines to help with their prescribing decisions.

The pharmacy had a whistleblowing policy for team members to use if necessary. Team members felt comfortable to raise professional concerns with management if required. They asked appropriate questions when selling medicines over the counter and were observed referring to the pharmacist to answer queries they were unsure about. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They would refer these requests to the pharmacist who would have supportive conversations with people. Team members also knew to refer to the pharmacist if there were concerns when people collected their prescriptions. For example, when people collected weight loss medicines provided by the company’s online prescribing service, if there

was a concern over their BMI. The pharmacy set its team members targets; 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 main dispensary was situated on the ground floor and was part of a large retail area. Upstairs, the pharmacy premises comprised of two additional rooms, one where multi-compartment compliance packs were dispensed and checked, and a second where medicines were dispensed and checked for care homes. On the ground floor adjacent to the main dispensary was a medicines counter. In all three dispensaries, there were different bench spaces for the completion of different tasks. The dispensaries were clean, and a cleaning rota was kept in the main dispensary which reflected tasks that were to be completed on a daily basis. The pharmacy had a cleaner who cleaned the dispensary more thoroughly, and this was completed when there was a team member present to ensure security of medicines and confidential information. The pharmacists checking benches allowed for effective supervision of the dispensaries and medicines counter on the ground floor. The main dispensary and care home room had a sink which provided hot and cold water and soap for handwashing. And toilet facilities were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a consultation room which was locked when not in use and allowed people to have private conversations and access services. It had a desk, chairs and a computer. The room had a glass door, with an internal curtain to provide privacy for people using the room. The consultation room did not have a sink, but it had hand sanitiser gel for pharmacists to use. A small hatch adjacent to the consultation room allowed privacy for those who were having their medicines supervised.

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 street and an automatic door which provided 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. They used translation applications for people whose first language was not English. There were healthcare leaflets on display in the consultation room for people to read or take away.

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 higher risk medicine such as methotrexate. 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. Team members were generally 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 medicines effectively. Some team members who were in training were not yet fully aware of the requirements. The pharmacy manager subsequently confirmed there was a person who received their medicine out with the original pack, and a risk assessment had been completed for this. Team members were observed asking appropriate questions when handing out medicines to people to ensure they were supplied to the correct person.

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 medicines to people living in care homes. The care homes ordered the prescriptions using repeat slips which were then sent to the GP surgery by the pharmacy. The pharmacy provided the care home staff with a list of medications that would be delivered for the next cycle starting ahead of time which meant that any queries about a person's medications could be resolved. The care home department had a dispenser who was also known as the "Care Services Partner" who was the main point of contact between the care home dispensary and the care home teams. The pharmacy provided the care homes with original packs of medicines and medication administration record charts. Communication forms were used by the care homes to update the pharmacy with information pertaining to residents, such as discontinued medicines or if any new prescriptions were required for medicines that were required out with the monthly medicines. The dispensary kept a progress record for each care home so that team members were aware which tasks had been completed for which care home. The pharmacy's delivery service delivered medication to people in the care homes. The delivery service also delivered medicines to people in their homes. Team members added deliveries to be made to an electronic platform and highlighted if fridge lines or CDs were included.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy ordered the prescriptions approximately three to four weeks in advance so any queries about a person's medication could be resolved. Each person had a medication record sheet which detailed the medicines taken and when. Any changes to a person's medication were communicated from the GP or from a hospital discharge letter and the person's medication record was updated. Team members provided descriptions of the medicines in the packs so they could be easily identified. And they provided people with patient information leaflets, so they had the correct information to take their medicines safely.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on shelves in the dispensaries. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure 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. Medicines expiring within the next few months were highlighted for use first and were recorded on a list. And they were removed the month before they were due to expire. A random selection of ten medicines found none past their expiry. Team members recorded the date of opening on liquid medicines that had a shortened expiry date on opening. One medicine was found to be past its expiry date after opening and this was removed during the inspection. The pharmacy had fridges to store medicines that required cold storage. Team members recorded the fridge temperatures daily, with records mostly showing the fridge was operating between the required two and eight degrees Celsius. The pharmacy had four examples of the fridge maximum temperature as being record above eight degrees Celsius, to a maximum of 8.6 degrees Celsius. There were no records seen of action taken as a result of this although the company did have a procedure to follow in the event of a temperature anomaly. Team members received notifications about drug alerts and recalls via NHS email. They printed, actioned and retained the NHS emails 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), British National Formulary for children (BNFc), medicines complete, and electronic medicines compendium (EMC). It had equipment needed for its services including in-date emergency adrenaline ampoules and pens used in vaccination services. It had equipment used in the provision of NHS Pharmacy First Plus, including an otoscope, pulse oximeter, thermometer and blood pressure monitor. The pharmacy had crown-stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. The pharmacy used a pump to measure doses of medicine used in the substance misuse service.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection adjacent to the medicines counter within the dispensary in a way that protected people's private information. Confidential information was secured on computers using 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.