General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 92 Kirkintilloch Road, LENZIE, East Dumbartonshire, G66 4LQ

Pharmacy reference: 1041992

Type of pharmacy: Community

Date of inspection: 22/11/2019

Pharmacy context

This is a community pharmacy in the centre of Lenzie. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers a smoking cessation service and seasonal flu vaccinations.

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 work to professional standards. They provide safe services and look after people's welfare. The team members discuss mistakes that happen when dispensing. But, as they don't always record much detail it is more difficult for the team to identify patterns in the mistakes. So, they may miss opportunities to improve and reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means that they listen to people and put things right when they can. The pharmacy encourages people to provide feedback about its services. And they make changes to their processes when they need to.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. And the team members were in the process of reading and signing the instructions to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. An experienced dispenser had taken the lead. And they were coaching the team members on a one-to-one basis to improve the quantity and quality of their near-miss records. This included reminding them to document the cause of the error. And explaining that this would lead to more effective risk management. The pharmacist and the dispenser had been reviewing the near-misses at the end of the month. And the pharmacy team had been discussing the findings. A sample report for September 2019 showed the following actions;
1. Take extra care when dispensing prescriptions for children.
2. Take extra care when handing out prescriptions.

The pharmacy team used the company's list of look-alike and sound-alike (LASA) medication to manage dispensing risks. And they kept the list beside the PMR and used shelf-edge caution labels to highlight stock, such as allopurinol and atenolol. The team members recorded LASAs on pharmacist information forms (PIFs). And this alerted the team members to take extra care when dispensing. The team members also identified LASAs that were causing local errors. For example, they had attached a shelf-edge caution label to levothyroxine and losartan medication. The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about an incident involving allopurinol and atenolol medication. And the pharmacist had instructed the team members to use a blue marker pen to highlight LASAs prescriptions. And this had been effective at managing errors. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used a practice leaflet to inform people about the complaints process. The pharmacy encouraged people to provide feedback about its services. And the team members had been taking extra steps to obtain stock when it had been in short supply.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid and up to date. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The NHS had commissioned the pharmacy to keep some drugs used in palliative care. And the team members checked the levels and the expiry dates to ensure ongoing availability. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy provided a delivery service to housebound and vulnerable people. And they made sure that people signed for their medication to confirm receipt. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions to improve access to medicines and advice. And a sample trimethoprim patient group direction was valid until August 2020.

The pharmacy displayed a notice which informed people about its data protection arrangements. The pharmacy trained the team members to comply with the arrangements. And they knew how to safely process and protect personal information. The team members used a blue coloured bag to dispose of confidential waste. And this was uplifted for off-site shredding. The team members archived spent records for the standard retention period. The pharmacy used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. And the pharmacist was registered with the scheme. The pharmacy trained the team members to comply with its safeguarding arrangements. And it provided contact details so that they knew who to contact if they had a concern about a child or an adult. The team members recognised the signs and symptoms of abuse and neglect. And knew when to refer to the pharmacist. The team members had referred a concern raised by a carer who reported that someone’s medication had gone missing. And it was not in the person’s home as expected. The pharmacist had listened to the concern. And had contacted the surgery to let them know. The team members had been made aware of the referral. And they had not received any further concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. The team members speak about mistakes when they happen. But, they do not always discuss the reasons for the mistakes. And this prevents the pharmacy team from learning from each other.

Inspector's evidence

The pharmacy had experienced a slight increase in the number of NHS prescriptions it received over the past year. The pharmacist carried out regular reviews. And this ensured the pharmacy had enough suitably skilled team members for the services it provided. The pharmacy team was mostly well-established. And a new trainee dispenser was being supported by the pharmacy team to build their confidence. The pharmacy team members were experienced and knowledgeable in their roles and responsibilities. And the following people were in post; one full-time pharmacist, one full-time dispenser, one full-time trainee dispenser, one part-time dispenser and three part-time dispensers.

The pharmacy had recently reduced its Saturday business hours. And it was closing at 1.00pm instead of 5.00pm. The dispenser's working arrangements had changed as a result. And they were working extra during the week. The pharmacist had been in post for around three months. And they had been carrying out needs assessments to ensure the pharmacy was safe and effective. The pharmacist had made changes and introduced new initiatives. For example, they were providing the flu vaccination for the first time at the pharmacy. And they had ensured that team members knew to provide advice when supplying NSAIDS. And that they knew about the valproate pregnancy protection programme and when to issue leaflets and cards.

The pharmacist had recently carried out performance reviews. And this ensured that team members improved and developed in their roles. The pharmacist encouraged the team members to develop. For example, they discussed the NVQ pharmacy services level 3 course with one of the experienced dispensers. And they had agreed to enrol on the course at the next student intake. The pharmacist was supporting the dispenser to develop in the workplace. And they had taken responsibility for carrying out the monthly near-miss review and for supporting less experienced team members. The company was supporting the pharmacist to develop. And they were attending off-site leadership training to develop in their role as a new manager.

The company provided a range of training resources. And the team members were up-to-date with mandatory training requirements. For example, they had recently completed information governance and safeguarding training. The team members had recently completed a module which promoted putting people first. And to be mindful that some people might need more support due to their health condition. For example, showing patience when people became frustrated. The team members used a monthly professional standards publication to learn about risks and how to avoid them. And they

discussed case studies to identify emerging risks, such as dispensing medicines for children and calculating doses.

The team members felt empowered to raise concerns and provide suggestions for improvement. And the new pharmacist had introduced a weekly huddle so that the pharmacy team were kept up to date. The pharmacist provided an update on how well the pharmacy was meeting its targets. And they discussed ideas about how they could increase the services that they were delivering. The pharmacy team members did not feel undue pressure to meet the targets. And they knew that the services were of benefit to people. For example, the chronic medication service (CMS), helped them to support people with compliance issues. The team members had suggested only ordering urgent stock to be delivered on a Saturday, with routine stock ordered to arrive on a Monday. And this had been agreed due to shorter opening hours on a Saturday.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. And the pharmacy provided seating and healthcare information leaflets for self-selection. The team members had allocated areas and benches for the different dispensing tasks. And they dispensed multi-compartment compliance packs on a bench at the rear of the pharmacy. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room and separate hatch. And both were professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had a stepped entrance. And a pressure operated door and an external door-bell provided extra support to people with mobility difficulties. The pharmacy displayed its opening hours in the window. And displayed healthcare information leaflets in the waiting area and in the consultation room. The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process.

The pharmacist had trained most of the team members to speak to people about their medication. And they registered suitable people with the chronic medication service (CMS) to support them to take their medicines as prescribed by the doctor. The team members attached laminated cards to prescriptions with high risk medicines. And this helped team members to communicate safety messages, such as checking that people taking warfarin medication were having regular blood tests. The team members registered people with a managed repeat dispensing service when it was appropriate to do so. And this helped them to support people to manage their medicines. The service accounted for around 50% of the prescriptions dispensed. And this also helped the team members to manage their work-load and optimise stock.

The pharmacy dispensed multi-compartment compliance packs for around 80 people who needed extra support with their medicines. And the pharmacy team members had signed to confirm they had read the working instructions to keep dispensing safe and effective. A lead dispenser was responsible for managing dispensing. And the other experienced dispensers had been trained to provide cover when required. The team members used trackers to manage the work-load. And this ensured people received their medication in good time. The team members isolated packs when they were notified about prescription changes. And they kept a record of any changes in the communications book and in the person’s notes. The pharmacy supplied patient information leaflets. And they annotated descriptions of medicines in the pack. The team members obtained signatures to confirm when packs had been collected. And this helped them to monitor supplies and to identify potential compliance issues which they referred to the pharmacist. The team members dispensed methadone doses on a Tuesday when it was quieter. And they obtained an accuracy check at the time of dispensing and at the time of supply to confirm that doses were in accordance with prescriptions.

The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The team members kept the pharmacy shelves neat and tidy. And they kept controlled drugs in a well-organised cabinet. For example, they kept expired and returned medication segregated at the bottom of the cabinet. The pharmacy team members had allowed a build-up of expired stock to accumulate. And they

needed to organise an authorised destruction with the relevant authority. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperature. And they demonstrated that the temperature had remained between two and eight degrees Celsius.

The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected. The pharmacy team members acted on drug alerts and recalls. And they recorded the outcome, and the date they checked for affected stock. For example, they had checked for ranitidine in November 2019 with stock quarantined and returned. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team did not know about the initiative, or when it was due to be introduced. The pharmacy team members had learned about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacy had not received prescriptions for affected people. But, knew to carry out checks to ensure that people had been provided with safety messages.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide safe services. But, it does not have the necessary arrangements in place to restrict access to some confidential information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. And the measures for methadone were highlighted and separated, so they used them exclusively for this purpose. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy used a tensor barrier to restrict access to the dispensary. But, this did not prevent people from being able to read some address labels on prescriptions bags that were waiting to be collected. The pharmacy arranged its computer screens, so they could only be seen by the pharmacy team. And the team members were able to take calls in private using a portable phone.

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.