General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 6-8 Brouster Gate, EAST KILBRIDE, Lanarkshire, G74 1LD

Pharmacy reference: 1042239

Type of pharmacy: Community

Date of inspection: 26/04/2023

Pharmacy context

This is a community pharmacy within a large shopping centre complex. It dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy provides a range of services including a substance misuse service, a home delivery service and the NHS Pharmacy First service.

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	1.2	Good practice	The pharmacy team is good at reviewing mistakes made during the dispensing process and can demonstrate how it uses the reviews to improve patient safety.
2. Staff	Standards met	2.4	Good practice	The pharmacy team demonstrates a good culture of learning and team members learn from other pharmacies and respond proactively to external incidents.
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 is good at reviewing mistakes made during the dispensing process and can demonstrate how it uses the reviews to improve the safety of its dispensing process. It effectively identifies and manages the risks associated with the services it provides to people. The pharmacy keeps most of the records it needs to by law and protects people's confidential information well. Pharmacy team members are suitably equipped to help protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The pharmacy was in the process of changing the SOPs from being in written form to electronic form. Team members were able to access the SOPs through their own personal smartphones or tablets at any time. Team members read the SOPs periodically and they completed a short quiz to assess their knowledge and understanding of the SOP. The responsible pharmacist (RP) had visibility of each team members progress record. This helped the RP check if a team member had not yet read an SOP that was relevant to their role. The RP demonstrated that all team members had read and understood the SOPs and had passed the relevant quizzes. The team had recently been provided with a new SOP outlining the process to record dispensing errors. The pharmacy employed an accuracy checking technician (ACT). The ACT was trained to undertake a final accuracy check of prescriptions. The pharmacy had a written procedure in place that clearly described the role and responsibilities of the ACT. The ACT and the RP annotated prescriptions which created a visual confirmation that the prescriptions had been accuracy and clinically checked. The ACT ensured they only checked prescriptions that were annotated by the RP.

The pharmacy had a documented procedure to support the team to highlight and record details of mistakes that were made during the dispensing process and spotted by the RP. These were known as near misses. The team had recently been provided with an updated SOP outlining the recording procedure. Team members recorded their own near misses onto an electronic reporting system. There was a quick link to the system installed on each computer terminal to help team members quickly access the system. The pharmacy had appointed a 'patient safety champion' (PSC) who was a senior team member. The PSC's responsibility was to assess the near miss record each month and identify if there were any patterns or trends. The PSC then held discussions with the team around how they could improve, and with each individual team member on a one-to-one basis. The findings of the team discussions were displayed onto a patient safety notice board which was located on a wall in the dispensary. Team members were encouraged to take the time to refer to the notice board so they could all learn from the information displayed. The team explained that most recently they had aimed to focus on making sure all team members were recording their near misses each time, so no learning opportunities were missed. Additionally, they talked about the importance of recording the reason a near miss might have happened so they could make specific changes to the way they worked to improve patient safety. The team discussed slowing down the dispensing process, so they didn't dispense under pressure. Team members had also highlighted and separated medicines that looked like or sounded like each other. These medicines were known as LASAs. The pharmacy used the same system to record and report dispensing errors which had reached people. Team members discussed these errors and made changes to reduce the risk of them happening again. The RP completed an incident report form which aided future learning.

The pharmacy had a procedure in place to support the handling of complaints or feedback from people who used the pharmacy. Team members explained they normally attempted to collect feedback and resolve any complaints from people verbally. If they were unable to resolve a complaint it was referred to the RP. If the RP was unable to resolve the complaint, the person was signposted to the pharmacy's head office team. The details of how people could make a complaint was outlined on the back of any till receipts provided to people.

The pharmacy had up-to-date professional indemnity insurance. It was displaying the correct responsible pharmacist (RP) notice. The RP register had been completed correctly. The pharmacy kept records of supplies against private prescriptions. However, on some occasions the team had not accurately recorded the details of the prescriber. The pharmacy retained controlled drug (CD) registers. And the team mostly kept them in line with legal requirements, however on some occasions the team had not recorded the full details of the wholesaler from which a CD was received. The team completed weekly balance checks of the CDs. The balance of a randomly selected CD was checked and was found to be correct. The pharmacy kept records of CDs returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The pharmacy displayed a privacy notice and how it managed people's confidential data. The team placed confidential waste into a separate bag to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information and they had all completed training about the General Data Protection Regulation (GDPR). The pharmacy had a formal written procedure to help the team raise concerns about safeguarding of vulnerable adults and children. And team members, including the RP, had completed some basic training on the subject. Team members described hypothetical safeguarding situations that they would feel the need to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough suitably skilled team members to manage its workload. It supports its team members to keep their professional knowledge and skills up to date. The pharmacy team demonstrates a good culture of learning and team members learn from other pharmacies and respond proactively to external incidents.

Inspector's evidence

At the time of the inspection the RP was supported by a full-time ACT, a full-time pharmacy technician and two full-time pharmacy assistants. Team members who were not present during the inspection included a full-time pharmacy assistant, a part-time second pharmacist and two trainee pharmacy assistants who worked only on Saturdays. The pharmacy received double pharmacist cover every Thursday and Friday. This helped the RP, who also had managerial responsibilities, complete administrative tasks and to help the team efficiently manage the dispensing workload. Team members covered each other's planned and unplanned absences, and they were able to request for additional dispenser support from the pharmacy's area manager if they felt the need to do so. Team members explained they were comfortable in their roles and felt the pharmacy benefited from good leadership. They were observed managing the workload well and supporting each other as they worked.

The pharmacy supported its team members to keep their knowledge and skills up to date through the use of an internal electronic training system. The company's head office periodically provided the team with mandatory modules to complete. For example, the team had recently completed training on the safeguarding of vulnerable adults and children. Team members were also able to voluntarily select modules to complete. Several team members had recently decided to complete training on hay fever to help them support people manage their condition in the upcoming summer months. Team members received protected time to complete their training but were not always able to take this time, and so did some of their training in their own time.

The team held several meetings throughout the working week. These meetings were an opportunity for the team to discuss patient safety, tasks to complete, raise professional concerns and provide feedback on how the pharmacy could improve service delivery. The pharmacy had undergone a recent refit. The team had discussed what they wanted to achieve from the refit and were able to give this feedback to the area manager. For example, the team requested for commonly dispensed medicines to be placed in lower drawers to make them easily accessible. The team was provided with a 'professional standards bulletin'. The bulletin informed the team of patient safety incidents that had occurred in other pharmacies within the company and encouraged the team to discuss the incidents and find ways of reducing the risk of the incidents happening with the pharmacy. The bulletin was provided in written form but also via an audio podcast. Team members explained they liked the podcast as it helped them learn in their own time. The team explained the latest bulletin highlighted a recent incident where the pharmacy had provided a person with two boxes of the same medicine, but the boxes were visually different. As a result, the person took two tablets, one from each box, instead of the prescribed dose of one tablet per day. To prevent a similar incident occurring, the team had started to leave a note for the RP if they had dispensed multiple packs of the same medicine that were visually different. The RP then advised the person collecting the medicines of the risk and how to take the medicines correctly.

The team was set some targets to achieve by the company. These included the number of prescription items dispensed and the number of service consultations completed. Team members agreed that the targets were generally achievable, and they were not under any significant pressure to meet them. They explained they always used their professional judgment to only offer services to people who needed them and their primary focus was to provide a safe and efficient service to people.

Principle 3 - Premises ✔ Standards met

Summary findings

On the whole, the pharmacy's premises are suitable for the services it provides and are appropriately maintained. The pharmacy has a suitably private consultation room where people can have a confidential conversation with a pharmacy team member. The pharmacy could do more to keep all areas clean and tidy, and free from potential tripping hazards.

Inspector's evidence

The pharmacy premises were clean, well maintained and portrayed a highly professional image. The dispensary was large enough to help the team manage the dispensing workload. And benches were kept tidy and well organised throughout the inspection. The floor space of the dispensary was kept clear of clutter to reduce the risk of trips or falls. There were several stock rooms and office spaces on the first and second floors. Some stock rooms were not kept tidy and floor spaces were cluttered with various miscellaneous items. This increased the risk of a team member tripping or falling in the room. The pharmacy had a suitable, private consultation room to support team members to have confidential conversations with people.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides a range of services which are easily accessible to people. These services are well managed, and the pharmacy provides them safely to people. The pharmacy correctly stores its medicines and team members complete regular checks of its medicines to ensure they are fit for purpose before they are supplied to people.

Inspector's evidence

The pharmacy had level access through an automatic door. The pharmacy advertised its services and opening hours in the main window. The pharmacy had a facility to provide large-print labels to people with a visual impairment and there was a hearing loop to help people with a hearing impairment.

Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply and had recently completed an audit of valproate patients confirming that they didn't supply to anyone in the at-risk group. The pharmacy team used laminated alert cards to highlight other high-risk medicine prescriptions that may require further intervention from the pharmacist.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members placed laminated alert cards into the baskets to highlight to the RP that there may be the need for additional counselling. They also used pharmacist information forms (PIFs) which they could annotate to provide the RP with any additional information. For example, if the person suffered from any allergies that may affect their treatment. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed the medicine and which team member had completed the final check. And they used a 'quad stamp' for team members to sign when the prescription had been dispensed, clinically checked, accuracy checked and then handed out.

The pharmacy sent a significant number of the prescriptions it received to be dispensed at the company's offsite dispensing hub pharmacy. Team members informed people of this process and made sure they had their consent for their prescriptions to be dispensed away from the pharmacy. Team members assessed prescription to ensure they were suitable to be sent to the hub pharmacy. Some prescriptions were unable to be sent to the hub and the team dispensed these locally. For example, prescriptions for urgent antibiotics or prescriptions for medicines that required cold storage. The RP completed an accuracy and clinical check of each prescription. Once these checks were complete the prescription was ready to be sent to the hub pharmacy for dispensing. The team kept physical copies of prescriptions that were sent to the hub pharmacy in a separate basket. And they were annotated to show they had been sent to the hub pharmacy. The dispensed medicines were received by the pharmacy approximately 48 hours after the prescription had been sent. The dispensed medicines were placed on the pharmacy's prescription retrieval shelves ready for people to collect them or for them to be delivered to people. The pharmacy kept records of the delivery service which they used to manage any queries.

The pharmacy stored pharmacy-only (P) medicines directly behind the pharmacy counter. The pharmacy had a process for the team to check the expiry dates of the pharmacy's medicines. The team demonstrated that it was up to date with the process. No out-of-date medicines were found by the inspector following a check of approximately 30 randomly selected medicines. The pharmacy had two medical grade fridges to store medicines that required cold storage. And the team kept records of the fridges' minimum and maximum temperature ranges. A sample of the records was seen which showed the fridges were operating within the correct ranges. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy received medicine alerts electronically through email and the company intranet. The team actioned the alert and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including access to online copies of the British National Formulary (BNF) and the BNF for children. The pharmacy used a range of CE marked measuring cylinders. There were separate cylinders to be used only for dispensing water. This helped reduce the risk of contamination. The automated dispensing machine was cleaned and calibrated each day. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.