General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 7 Baljaffray Shopping Centre, Grampion Way, Bearsden, GLASGOW, Lanarkshire, G61 4RN

Pharmacy reference: 1042374

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

This is a community pharmacy located in a small shopping centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines' delivery service. And it 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 also offers a smoking cessation 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 has embedded continuous improvement in its practices. The pharmacy team ensures it learns when things go wrong. And it takes its time to discuss and identify risks so that the safety and effectiveness of its services continue to improve.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
		2.4	Good practice	The pharmacy team members work effectively. And they are comfortable talking about their weaknesses and the importance of shared learning. They focus on continuous improvement. And they want to provide good outcomes for people.
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 understand their role in protecting vulnerable people. And they 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 they listen to people and put things right when they can. Pharmacy team members record and discuss mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And it provides training for the team on how to keep confidential information. It has controls in place to keep people's private information secure.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacist displayed the responsible pharmacist notice. But it was not visible from the waiting area. And people could not identify the pharmacist in charge. The pharmacy team members 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. The pharmacist placed the near-miss record book into affected dispensing baskets. And this ensured that team members documented their errors. The team members reflected on their errors to identify what the aggravating factors might have been. And they recorded the details on the near-miss record sheet. The quantity and quality of the records enabled the team members to identify patterns and themes. And they discussed significant events when they emerged. The trainee pharmacy technician carried out the formal near-miss reviews at the end of the month. And the pharmacy team discussed the findings and the action they planned to take. Sampling showed they achieved good outcomes due to the quality of the data recorded. For example, they had agreed to document and highlight 'look-alike and sound-alike' (LASA) products on the 'pharmacist information form' (PIF). And the dispensers had agreed to always tick the PIF to confirm they had carried out an accuracy check before passing to the pharmacist who also ticked the PIF to confirm they had carried out the necessary checks. And this had been effective at reducing errors with LASA products. The team members had added tetracycline/terbinafine to the list issued by the Superintendent's office due to an emerging trend seen at a recent near-miss review. The company issued a monthly professional standards newsletter to help the team members to manage risks. And they discussed the topics at the monthly patient safety review meeting. For example, they had discussed the need to counsel parents and carers on how to use oral dose syringes. And not to make assumptions that people knew how to use them. They also discussed the prescription 'hand-out' process to confirm they were maintaining the necessary controls to manage the risk of 'hand-out' errors that the company had classed as a 'never-event'.

The pharmacist was responsible for managing the incident reporting process. And they knew to update the pharmacy team members when incidents happened and what the cause had been. The pharmacist used the web-based incident reporting template. And they produced two separate reports showing the outcome of previous investigations and the improvements that they made. The team members had separated gabapentin products. And they had added a caution label to the affected shelves. The team members knew about the error. And they made sure they used the 'pharmacist information forms'

(PIFs) to highlight the product. The team members had also re-arranged the dispensing benches. And they had created a separate checking bench that was well-away from the dispensing bench and facing away from the waiting area and its distractions.

The pharmacy used a complaints policy to help the team members handle complaints in a consistent manner. And it provided information to help people to submit complaints if they needed to. The pharmacy encouraged people to provide feedback about the services they received. And this had been mostly positive with no suggestions for improvement.

The pharmacy maintained the 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 an up to date. The pharmacy team members kept the controlled drug registers up to date. And they carried out balance checks on a weekly basis, with methadone checked to include the manufacturer's overage. 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. 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 (PGDs) to improve access to medicines and advice. And a sample showed that the NHS Greater Glasgow & Clyde trimethoprim PGD was valid until August 2020. The pharmacy used a leaflet to inform people about its data protection arrangements. And it informed people about how it kept their personal information safe. The company provided regular training to ensure the team members complied with the general data protection regulations. And they knew how to safely process and protect personal information. The company collected confidential waste for off-site shredding. And they 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 company provided regular training to ensure it supported the team members to comply with its safeguarding protocols. The team members had identified their vulnerable groups. And they knew to speak to the pharmacist when they had concerns about individuals. This meant they could take the appropriate actions to protect individuals and support vulnerable people. For example, they had looked after an elderly man who had suffered a fall. The team members had provided him with a topical preparation to treat the graze. And they spoke to him whenever he visited the pharmacy to make sure he was in good health.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members discuss their development needs at regular review meetings. And they are encouraged and supported to develop their skills. The pharmacist supports the pharmacy team members to learn. And this ensures they keep up-to-date and current in their roles. The pharmacy team members support each other in their day-to-day work. They can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy workload had increased by around 1000 items per month since the previous year. The pharmacist carried out regular reviews to ensure the pharmacy team continued to have the capacity and capability to provide the services it offered. And they had recently been authorised to appoint a new part-time dispenser to work 20 hours each week to help them manage the extra demand on services. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles and responsibilities. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, two part-time dispensers, one full-time trainee pharmacy technician, one part-time trainee dispenser and one delivery driver. The pharmacist managed annual leave requests. And the team members provided cover for each other. The pharmacist maintained minimum levels. And they authorised only one team member to be off at the same time.

The pharmacists carried out regular performance reviews to help the team members improve and develop in their roles. And the part-time dispenser had registered their interest in the NVQ pharmacy services level 3 course. The pharmacist supported the team members to learn and develop. For example, they provided the trainee pharmacy technician with protected learning time. The company provided structured training. And this ensured the team members stayed current in their roles. For example, they had recently completed safeguarding and data protection training. The company tested the team members to confirm that the learning had been effective. And they had to complete the module a second time if they failed to achieve the pass-mark.

The pharmacist delegated responsibility to the team members. And one of the dispensers had been nominated to take the lead on re-ordering repeat prescriptions. The team member reconciled the prescriptions when they arrived back from the surgery. And they contacted the surgeries to query missing prescriptions. This ensured they received prescriptions in plenty of time. And helped them to meet their service standards. For example, people not having to visit the pharmacy more than twice to collect the same prescription. A full-time medicines counter assistant was responsible for managing the queue at the counter. And this was due to a significant number of people waiting to collect their prescriptions. The medicines counter assistant knew to liaise with the dispensers. And to provide realistic waiting times to manage the risk of dispensing errors.

The company used performance targets to grow the services it provided. And the team members were focussed on speaking to people about the pharmacy's ‘managed repeat dispensing service’ (FRPS) when appropriate. The team members did not feel undue pressure when carrying out tasks. And knew only to

speak to people when appropriate. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, a dispenser had recently introduced red dispensing baskets for controlled drug (CD) prescriptions. And this ensured CD dispensing was prioritised and additional regulatory tasks were completed. For example, recording information about supplies in the controlled drug registers.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is clean and hygienic. It has a consultation room that is professional in appearance. And it provides 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 it provided seating and some patient information leaflets for self-selection. The waiting area became congested due to the increased demand for prescriptions. And due to people wishing to wait on their prescriptions being dispensed. The dispensary had sufficient benches and storage space for its workload. And the team members kept them organised and clutter free.

The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy had a consultation room. And it was professional in appearance and provided an area for people to speak to the team members in private.

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 step-free access and a pressure operated door. And the team members had good visibility of the entrance so they could provide assistance if necessary. The pharmacy kept a few leaflets in the waiting area and its opening hours in the window. And it displayed the NHS recommended public information about COVID-19 at the entrance to the pharmacy. The pharmacist had spoken to the team members about the COVID-19 virus. And they knew to use the consultation to isolate people who entered the pharmacy and it emerged they may be affected by the virus. The Superintendent's office had issued support materials to keep the pharmacy team up-to-date. And the pharmacist was monitoring the media to keep up-to-date.

A managed repeat dispensing service (FRPS) accounted for around 50% of the prescriptions dispensed. And the team members re-ordered and collected prescriptions for people who received regular prescriptions. The team members were able to collect prescriptions in advance. The pharmacy had seen an increase in the number of people who wanted to wait on their prescriptions being dispensed in advance. And the team members knew to increase the waiting time when demand peaked, and to suggest that people could come back later if they were planning on shopping in the nearby supermarket. And this helped them to dispense medication in good time.

The pharmacy team members used supplementary records to manage repeat dispensing. And they knew when people arrived too early or too late for their medication. This prompted them to inform the pharmacist who spoke to people to identify if they were having difficulties with their medicines. The pharmacy team members had not been registering new people with the multi-compartment compliance pack dispensing service since the middle of 2019. And this was due to the available space and resources needed to carry out dispensing. The pharmacy dispensed packs for around 26 people. And the team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. The team members isolated packs when people's prescription needs had changed/were changing. For example, when they went into hospital. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members kept a signature audit trail to show who had dispensed and who had checked the packs. And this helped them to identify dispensing risks and areas for improvement. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines correctly. The pharmacy team members issued packs to people in the pharmacy. And they asked a colleague to check the person's name and address to manage the risk of 'hand-out' errors. The pharmacy provided a delivery service to housebound and vulnerable people. And they obtained signatures to confirm receipt.

The pharmacy team members used dispensing baskets. And they kept prescriptions and medicines contained throughout the dispensing process. The team members dispensed methadone doses once a week for around two people. And they obtained an accuracy check at the time of dispensing and when people arrived for their doses. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities to check for short dated stock and split-packs. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. 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 controlled drugs in a separate cabinet. And they managed the risk of selection errors, for example, by keeping out-of-date and returned medication separate from routine stock until they carried out destructions.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in February 2020 they had acted on an alert concerning Oxylan. And on checking the shelves they had no affected stock. The company had trained the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The company had not trained the team members about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And they were not using the system in their day-to-day processes. The team members confirmed that the company had announced it was due to introduce the system. And they expected to be trained in the relevant processes and procedures.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

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, so they were used 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 stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members had access to a portable phone. And they were able to take calls in private when necessary.

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.