General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 92 Kilmarnock Road, Shawlands, GLASGOW, Lanarkshire, G41 3NN

Pharmacy reference: 1042402

Type of pharmacy: Community

Date of inspection: 30/07/2024

Pharmacy context

This is a community pharmacy on the outside of an arcade of shops in the city of Glasgow. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help to take their medicines at the right time. And it provides a private seasonal vaccination service. Pharmacy team members provide advice on minor ailments and medicines' use.

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 appropriately identifies and manages the risks with the services it provides. Pharmacy team members record and discuss mistakes identified during the dispensing process and they make changes to prevent the same mistake happening again. And they understand their role in helping to protect vulnerable people. The pharmacy keeps the records it needs to by law, and it suitably protects people's confidential information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) available to its team members designed to help them work safely and effectively. Most of the SOPs were accessed electronically but a small number of SOPs were paper-based and kept in a folder. They included SOPs about the absence of the Responsible Pharmacist (RP) and the management of controlled drugs (CDs). SOPs were reviewed by the Superintendent Pharmacist (SI) team every two years. And team members completed an online competency assessment to show they had read and understood them. Notification of new or updated SOPs were communicated with team members via email. Team members roles and responsibilities were clearly defined in paper-based records, and they accurately described what activities they could and couldn't undertake in the absence of the RP. And there was a business continuity plan in place to address disruption to services or unexpected closure.

A signature audit trail on medicines labels showed who dispensed and checked each medicine. This meant the RP was able to help team members learn from dispensing mistakes identified within the pharmacy, known as near misses. The pharmacy kept electronic records of near misses and included details such as the date and time the near miss happened, and any contributing factors. Team members were encouraged to record the near miss when it happened as a method of reflection following a mistake. Mistakes that were identified after a person received their medicines, known as dispensing incidents, were recorded on an online system, and then reviewed by the SI team at head office. A patient safety review audit was carried out on near misses and dispensing incidents by the trainee pharmacy technician once a month. Team members then discussed the findings from the audit and agreed actions which they put in place to manage the risk of the same or similar mistake happening again. This included implementing a 'select with care' prompt in the form of a label. This label was attached to the shelves of specific medicines that had been identified during the audit, which included higher-risk medicines such as risperidone, and mebeverine due to increased errors related to the pack size. The regular pharmacist was an independent prescriber (PIP) and was currently undertaking an audit of their prescribing decisions under the NHS Pharmacy First Plus service. This audit included capturing information about common trends and how many consulations resulted in referral. The audit would allow the PIP to analyse the data and identify any gaps in knowledge or scope of practice.

The pharmacy had a complaints procedure and welcomed feedback. There was a quick response (QR) code available in the retail area for people to scan to provide feedback about the service they had received. At the time of inspection, a person collecting their prescription provided positive verbal feedback to the pharmacy team for the service they had received. Team members were trained to resolve complaints and aimed to do so informally. However, if they were not able to resolve the complaint, they would provide contact details for the SI team.

The pharmacy had current professional indemnity and liability insurance. The pharmacy displayed an RP notice that was visible from the waiting area and reflected the correct details of the RP on duty. And the paper-based RP log was up to date. Team members maintained paper-based CD registers but there were minor omissions of the delivery address of the wholesaler. This was discussed at the time of inspection and the RP provided assurances this would be addressed. They checked the quantities in stock matched the balances recorded in the CD registers weekly. A random check of the quantity of three CDs was correct against the balances recorded in the registers. The pharmacy kept records of CDs that people had returned for safe disposal. Records of private prescriptions were kept electronically and were complete. And records of unlicensed medicines were up to date.

There was a chaperone policy and data protection notice on display and team members knew how to protect people's confidential information. Confidential waste was segregated and collected by a third-party contractor to be securely destroyed off-site. There was a safeguarding policy in place and team members completed online training relating to the safeguarding of vulnerable people. And they discussed any safeguarding concerns with the RP. Team members provided examples of signs that would raise concerns and interventions they had made to protect vulnerable people. Contact details for local safeguarding agencies were on display in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary skills and knowledge they need for their roles and the services they provide. They manage their workload well and support each other as they work. And they feel comfortable raising concerns and discussing improvements to provide a more effective service.

Inspector's evidence

The pharmacy employed one full-time pharmacist who was an independent prescriber, a full-time dispenser who was the store and pharmacy manager, one full-time dispenser, two part-time dispensers and a full-time trainee pharmacy technician. At the time of inspection, a pharmacy student was on placement within the pharmacy. The pharmacy used a delivery driver organised by the company to collect prescriptions from local GP practices, they did not provide a prescription delivery service to people's homes. Team members were observed managing the workload well and providing support to each other as they worked. The pharmacy manager managed annual leave requests to ensure staffing levels remained sufficient to manage the workload safely. Contingency cover was available during periods of absence.

Protected learning time and training plans were provided for team members undertaking accredited qualification courses. And for the introduction of new services or for specific continued learning and development. Team members had attended face-to-face training for specific services they provided such as injection equipment provision, seasonal flu vaccinations and the NHS Pharmacy First Plus service. The team regularly discussed ongoing learning points such as counselling for different medicines. A team member explained they had noticed a recent increase of prescriptions for Wegovy weight-loss injections via Boots Online Doctor. The RP used this as an opportunity as team learning. They discussed counselling and monitoring required for people receiving this medicine, and how the injection should be administered safely. Team members received appraisals annually with the pharmacy manager to review progress and identify any individual learning needs. They asked appropriate questions when selling over-the-counter medicines. And they explained how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines by referring to the RP or person's GP for supportive discussions. The pharmacy had a close working relationship with local GP practices. A team member described a recent practice visit in which they met with the practice manager to provide an update on the NHS Pharmacy First Plus service. This included providing resources to the GP practice team such as conditions that could be treated within the service's scope of practice and when referrals to community pharmacy was not appropriate. The pharmacy noticed a decrease in inappropriate referrals after the visit. The PIP worked with other local prescribers and in periods of the PIPs absence, team members signposted people to other prescribers close by.

Team members were encouraged to make suggestions to improve the ways of working within the pharmacy. There was a whistle blowing policy in place and team members explained they would feel comfortable raising concerns with the RP or SI team. The pharmacy manager attended weekly conference calls and a monthly governance call with the area manager and other branch managers to receive relevant updates and raise any concerns. This provided an opportunity for professional learning and peer review. Team members were set targets from the company but did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and provide a professional environment suitable for the services it provides. It has a private consultation room where people can have confidential conversations with a member of the pharmacy team if needed.

Inspector's evidence

The pharmacy premises were clean, secure, and provided a professional image. There was a large well-presented retail area which led to a healthcare counter and dispensary. Pharmacy-only medicines were stored behind the healthcare counter and this acted as a barrier to prevent self-selection. And team members kept activity in the area under constant supervision. The dispensary was laid out in a way which allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. Medicines were stored neatly around the perimeter of the dispensary and on shelves throughout. The dispensary was adequately sized, well organised and the team members managed the space well. It had a sink with access to hot water for professional use and hand washing. And there was a second private area used for substance misuse supervision. There was a storage area for online orders awaiting collection and a large space upstairs. It was compromised of a stock room, a cash office with a computer for team members to complete different tasks and staff facilities which were hygienic with access to hot water.

The pharmacy had a consultation room which was clearly advertised. It was clean, appropriate in size and fit for use. Lighting and temperature were kept to an appropriate level throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. And they make them easily accessible to people. The pharmacy suitably sources its medicines from recognised suppliers and stores them appropriately. And team members carry out the appropriate checks to ensure they continue to be suitable for use.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It advertised its opening hours in the main window. The pharmacy had a range of healthcare leaflets for people to read or takeaway relating to different healthcare conditions. And it advertised services available in the local community such as counselling services. Pharmacy team members had access to a translator service to communicate with people who did not use English as their first language. And they had the facilities to provide large-print labels to help people with visual impairments take their medicines safely. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members checked the expiry dates of medicines and recorded their actions on a date checking matrix. And they attached stickers to medicine boxes with a shorter expiry date to indicate it should be used first. Records showed date checking was up-to-date and a random selection of 20 medicines showed one had expired. This was highlighted to the pharmacy manager during the inspection. The pharmacy used one well organised fridge to store its medicines and prescriptions awaiting collection which required cold storage. And team members recorded the temperature daily with records showing the fridge was operating within the recommended limits of between 2 and 8 degrees Celsius.

Team members used baskets during the dispensing process to separate people's prescriptions and prevent medicines from becoming mixed-up. And they highlighted the inclusion of a fridge line, CD and higher-risk medicines which required further counselling by attaching coloured cards to the outside of the bags of dispensed medicines. Team members were aware of the Pregnancy Prevention Programme and of the risks associated with valproate-containing medicines. They always supplied valproate-containing medicines in the manufacturers original packaging, and they supplied Patient Information Leaflets (PILs) and patient alert cards with each supply. The pharmacy received Medicines Healthcare and Regulatory Agency (MHRA) patient safety alerts and medicines recalls via email. The clinical mailbox was checked three times a day and recalls were actioned on receipt and a team member signed this when the appropriate action had been taken. Team members kept paper-based records of actions taken for future reference. Some people received serial prescriptions under the Medicines: Care and Review service (MCR). Team members worked on an eight weekly cycle and prepared prescriptions in advance of people's expected collection dates. The pharmacy maintained records of each supply and expected collection dates. This allowed them to plan their workload in advance. And helped the pharmacist identify any issues with people not taking their medicines as they should. The pharmacy provided a text message service to alert people when their prescription was ready to be collected. They obtained consent for this service and kept records of this.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested to help them take their medicines properly. Team members worked on a four-week cycle, this allowed them sufficient time to resolve any queries with people's medication. They maintained a record of each person's current medicines on a master sheet. This was checked against prescriptions before

dispensing. Team members attached dispensing labels to each pack which included warning labels for each medicine, instructions for use and a description of what each medicine looked like. They included patient information leaflets (PILs) monthly to ensure people had up-to-date information relating to their medicines. Team members used communication forms to record any discussions with other healthcare professionals or relevant information relating to people's medicines supplied in multi-compartment compliance packs.

The pharmacy provided a local NHS injection equipment provision service. It provided equipment, as well as advice and information. Team members were trained to ask appropriate questions and gather relevant information under the supervision of the pharmacist. They kept records on an online platform as well as any concerns or notable information. They were supported by local substance misuse team members. And pharmacy team members received refresher training to continue to be able to provide the service safely.

The pharmacy team members were trained to deliver the NHS Pharmacy First service within their competence and under the supervision of the pharmacist. The PIP provided the NHS Pharmacy First Plus service. They treated several common clinical conditions including those affecting the ears, skin, throat and chest. They were supported by other prescribers within the company. The PIP worked under an agreed scope of practice that listed medicines that could be prescribed, provided supporting information for the prescriber, and documented when referral to a GP would be appropriate. They held consultation records electronically and these were communicated to people's GP via email. This ensured people's medical records were kept up to date. The pharmacy provided an appointment based private seasonal flu vaccination service to people in the local community. And they kept records of administration.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to appropriate equipment that is fit for purpose and safe to use. And team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had access to resources such as the British National Formulary (BNF) and the local health board formulary. Team members were able to access electronic resources to obtain up-to-date information and guidelines to support them in their roles.

A range of equipment was able for use in the consultation room, including an otoscope, blood pressure monitor and thermometer. They were newly purchased to allow the PIP to provide the NHS Pharmacy First Plus service and were fit for use. The pharmacy had clean CE-stamped measuring cylinders and tablets counters. And they had highlighted specific measures to be used solely for the purpose of measuring substance misuse liquids.

Prescriptions awaiting collection were stored in a retrieval area behind the healthcare counter and confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevented unauthorised view. And cordless telephones were in use to allow for private conversations in a quieter area.

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.