General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 240 Main Street, Rutherglen, GLASGOW, Lanarkshire, G73 2HP

Pharmacy reference: 1042428

Type of pharmacy: Community

Date of inspection: 15/01/2024

Pharmacy context

This is a pharmacy on a main street in the town of Rutherglen, Glasgow. Its main activities are dispensing NHS prescriptions and providing some people with medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides the NHS Pharmacy First service and team members give advice and sells medicines to help people with their healthcare needs.

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 help manage risk so its team members can provide services safely. Team members record errors made during the dispensing process so they can learn from them. They keep records required by law and keep people's private information secure. They know how to respond effectively to concerns from 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 (SI) pharmacist 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. And they completed quizzes to confirm their understanding of them.

The pharmacy recorded errors identified during the dispensing process known as near misses. The team member who made the error was responsible for recording the details of the error. Records showed that errors generally involved the wrong quantity of medicine being dispensed, or incorrect directions being typed on labels. Team members had informal conversations regarding the errors and made some changes to their dispensing processes. For example, medicines that could not be barcode scanned during the dispensing process were double checked for accuracy by a second team member. And team members had moved certain higher-risk medicines such as quetiapine to a separate area of the dispensary. The pharmacy completed incident reports for errors that were not identified until after a person had received their medicine. These were recorded electronically and shared with the area manager. The pharmacist completed a monthly patient safety review with action points to help prevent any future near misses or dispensing incidents. 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. If they were not able to resolve the complaint, they provided people with the details of the customer care team at the company's head office. Team members sought feedback from people accessing the services in the form of surveys.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And they knew which tasks could and could not be completed in the absence of the RP. The RP notice was displayed prominently in the retail area and reflected the details of the RP on duty. The RP record was compliant. The pharmacy had a paper-based register for recording the receipt and supply of its controlled drugs (CDs). The entries checked were in order, with some minor omissions of the wholesaler address for received medicines. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them. It kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept electronic records for its supply of private prescriptions and kept associated paper prescriptions.

The pharmacy had a data processing notice in the retail area of the pharmacy which informed people of how their data was used. Team members received annual training regarding information governance (IG) and general data protection regulations (GDPR). The pharmacy had separate bins for confidential waste which were collected for destruction. And it stored confidential information in staff-only areas. It

displayed a chaperone policy at the consultation room, informing people of their right to have a chaperone present for consultations completed in the consultation room if required. Team members received annual training for safeguarding. And they had access to contact details for local authorities. They knew to refer any concerns to the pharmacist and gave a recent example of an incident which they reported to the appropriate authorities. The pharmacist was part of the protecting vulnerable groups (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members complete ongoing learning to help develop their skills and knowledge. And they suitably respond to requests for advice and sales of medicines.

Inspector's evidence

The pharmacy employed a regular part-time pharmacist. A second pharmacist was due to begin working in the pharmacy the following week to help cover the pharmacy's opening hours. Other team members included five trained dispensers, one of whom was the pharmacy manager, and a trainee dispenser. Team members had either completed accredited training for their roles or were completing an accredited training course. The pharmacist had completed training to allow them to deliver services, such as influenza vaccinations. Team members received regular updated learning which included online training modules and monthly newsletters from the company to help develop their knowledge. The monthly newsletter included shared learnings from other pharmacies in the company which team members could implement or be aware of. And team members signed to say they had read it. They completed their learning during quieter periods during the working day. They were learning about information governance (IG) this month and had reviewed their knowledge of CD SOPs during the previous month. Team members supported each other and gave an example of shared learning concerning the recording of CD medicines returned by people who no longer needed them.

Team members were observed working well together to complete the workload. Requests for annual leave were planned in advance so the pharmacy was able to arrange contingency for absence. The pharmacy used team members from other pharmacies in the company if necessary, or part-time team members increased their hours to provide support to cover absences. Team members had received a performance review in the past year. They were offered opportunities to develop their knowledge and skills by undertaking additional qualifications. There was an open and honest culture amongst the team, and they felt comfortable to raise concerns with management if required.

Team members asked appropriate questions when selling medicines over the counter and referred to the pharmacist if necessary. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines used to treat insomnia. And they referred such requests to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has a spacious consultation room where people can have private conversations with team members.

Inspector's evidence

The premises were comprised of a large retail area to the front and a dispensary to the rear. The pharmacy had a medicines counter which was well organised and portrayed a professional appearance. Team members prevented unauthorised access to the dispensary, which was clean and tidy. There was an organised workflow and designated spaces for the completion of tasks and storage of medicines. The pharmacist's checking area allowed for effective supervision of both the dispensary and medicines counter. This allowed them to intervene in conversations at the medicines counter if necessary. Medicines were stored neatly in alphabetical order on shelves. The dispensary had a sink which provided hot and cold water and soap for handwashing. And toilet facilities were clean and had separate handwashing facilities. The pharmacy had a cleaner who cleaned the dispensary thoroughly three times a week. And team members ensured benches were cleaned daily in between. Lighting was bright throughout, and the temperature was comfortable.

The pharmacy had a spacious soundproofed consultation room which allowed people to have private conversations and access services. There was a desk and chairs for consultations to be completed comfortably. The consultation room was locked when not in use.

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 source medicines from licensed wholesalers. They carry out checks to ensure medicines remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines. Team members supply people with necessary information to help them take their medicines safely.

Inspector's evidence

The pharmacy had an automatic door and level access from the street which provided ease of access to those using wheelchairs or with prams. And it used a hearing loop for those with hearing difficulties and provided some people who had visual difficulties with large print labels. It had a range of healthcare leaflets for people to read or take away, which included information on the NHS Pharmacy First Service. Team members were observed referring people to another pharmacy for services they did not offer such as the NHS Pharmacy First Plus service. The pharmacy's services such as NHS Pharmacy First and provision of emergency hormonal contraception were underpinned by patient group directions (PGDs) which the pharmacist accessed online. The pharmacy received private prescriptions from the company's associated online doctor service. The pharmacist was able to contact the service directly with any queries about the prescriptions, including a medicine being prescribed for an unlicensed indication.

Team members used baskets 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. Laminated cards were attached to prescriptions to highlight fridge lines, CDs or higher-risk medicines such as valproate. Team members were 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 safely. They knew about a recent update regarding the supply of valproate in the original manufacturer's packs. Team members confirmed they did not currently dispense for any people in the at-risk category. But they confirmed they had people who received valproate in multi-compartment compliance packs and these people received their valproate in original packs. The pharmacist had printed a company issued alert regarding the changes and stored it alongside the valproate packs on the shelf, so that team members had up-to-date information to refer to when dispensing. Team members were observed asking appropriate questions when handing out medicines. And they used the laminated cards as a prompt to give people additional counselling and check they had received appropriate monitoring when handing out other higher-risk medicines such as warfarin and methotrexate.

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 the medicine was ready for people to collect. The pharmacy provided the Medicines: Care and Review (M:CR) service. Team members prepared the medicines ahead of them being needed. And they annotated when medicines were collected and next due so they could manage the service effectively. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines. Team members were responsible for ordering prescriptions and did so a week in advance of them being

required so that any queries could be resolved in a timely manner. Each person had a medication record sheet, documenting their medicines and dosage times. And any changes to their medication were documented on their record. Team members provided descriptions of the medicines in the pack so they could be easily identified. And they provided people with the necessary information to take their medicines safely , including warnings on dispensing labels and patient information leaflets (PILs).

The pharmacy sourced its medicine from licensed wholesalers, and it kept medicines in original containers. Pharmacy only (P) medicines were stored behind the medicines counter which ensured sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. They completed checks of different sections in the dispensary on a weekly basis and this was up to date. Medicines expiring in the next three months were highlighted for use first. And medicines with a shortened expiry date on opening were marked with the date of first opening. But two such medicines on the shelf had expired. The pharmacist removed these for destruction during the inspection and identified a learning opportunity for team members who completed date checking. A random selection of 15 medicines found no out-of-date medicines. And team members confirmed they checked the expiry dates of medicines as part of their dispensing process. The pharmacy had a fridge to store medicines that required cold storage. And team members recorded the temperature daily, with records showing that the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via emails and directly from the company on an online platform. They printed and actioned alerts and stored them for future reference. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment its 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 up-to-date reference resources including paper and electronic versions of the British National Formulary (BNF) and British National Formulary for children (BNFc). It had equipment it needed for its services including an in-date adrenaline kit used for the influenza vaccination service. Team members used a measuring device known as a pump for measuring doses of medicine used in the substance misuse service. They confirmed they had arranged for it to be calibrated and were waiting for this to be actioned. And team members manually checked it poured accurate measurements on a daily basis. The pharmacy had clean crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had clean triangles and capsule counters used to count tablets and capsules during the dispensing process. And there was a separate triangle used to count cytotoxic tablets.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines waiting collection in a way that prevented unauthorised access to people's private information. Confidential information was secured on computers using passwords. And screens were positioned within the dispensary so that 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.