General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 426 Victoria Road, GLASGOW, Lanarkshire, G42 8YU

Pharmacy reference: 1042523

Type of pharmacy: Community

Date of inspection: 24/06/2024

Pharmacy context

This is a community pharmacy located within a parade of shops in the city of Glasgow. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. And it dispenses medicines in multi-compartment compliance packs to help people take their medicines safely. The pharmacy provides substance misuse services and a delivery service. The pharmacy team provides advice on minor ailments and on medicines' use.

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 suitably identifies and manages the risks with the services it provides. Pharmacy team members record and discuss mistakes made during the dispensing process and they make changes to help 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 which were designed to help them work safely and effectively. They were accessed electronically and included SOPs such as absence of the Responsible Pharmacist (RP) and how to safely report an incident. SOPs were reviewed by the Superintendent Pharmacist (SI) every two years. And team members completed an online assessment and declaration to show they had read and understood them. Notification of new or updated SOPs were communicated with team members via email. Team members described their roles and responsibilities within the pharmacy and 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 medicine 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 time and date the near miss happened, and any contributing factors. Team members were encouraged to complete the near miss record themselves as a method of reflection following a mistake. Mistakes that were identified after people received their medicines, known as dispensing incidents, were recorded on an electronic system, and then reviewed by the SI team at head office. A monthly safety audit was carried out on near misses and dispensing incidents by a different team member each month. Team members then discussed the findings from the audit and agreed actions which were put in place to manage the risk of the same or a similar mistake happening again. This had included implementing a second check on all medicines stored loose in bottles and liquids before the final check was completed. And they had introduced an audit trail of checks of quantities of tablets inside each compartment of a multi-compartment compliance pack due to a trend in mistakes. The pharmacy completed regular audits of the services they provided and the equipment they used. Following an audit, where discrepancies were identified in quantities dispensed via the automated dispensing pump used to measure some substance misuse liquids they reverted to measuring these medicines using CE-stamped measuring cylinders. And they kept records to show they had reported this following company procedures.

The pharmacy had a complaints procedure and welcomed feedback. There was a quick response code available in the retail area for people to scan to provide feedback about 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 details for the customer care team or SI.

The pharmacy had current indemnity insurance. The pharmacy displayed an RP notice which was visible from the retail area, and the paper-based RP log was up to date. Team members maintained complete

paper-based controlled drug (CD) registers and they checked the quantity in stock matched the balances recorded in the registers weekly. A random check of the quantity of two CDs was correct. The pharmacy had records of CDs people had returned for safe disposal. Private prescription records held electronically were complete. And records of unlicensed medicines were up to date.

There was a chaperone policy and data protection policy 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 destroyed off-site. Team members had 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 the team had made to protect vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary skills and qualifications 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 part-time pharmacist who was the pharmacy manager and an independent prescriber (PIP), one full-time trainee pharmacist, two full-time dispensers, two part-time dispensers and a trainee dispenser. A nursing student and a pharmacy student worked on Saturdays. The pharmacy offered a delivery service twice a day, and the delivery drivers who were organised by the company were not the same delivery driver each time. Delivery drivers planned their route daily. And they used an electronic device to record the delivery of each prescription. Team members were experienced in their roles. They were observed providing support to each other as they worked and seen to be managing the workload well. The RP 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 was provided for staff 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. They received appraisals annually with the pharmacy manager to 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. They explained how they would refer to the RP or the person's GP for supportive discussions. The pharmacy had a close working relationship with local GP practices. A team member described an education session they provided to the GP practice team on the NHS Pharmacy First service. This improved ways of working between the GP practice and pharmacy teams. And pharmacy team members noticed an increase in referrals for NHS Pharmacy First consultations following the education session.

There was a clear culture of openness and honestly within the pharmacy. And team members were encouraged to make suggestions to improve their ways of working. There was a whistle blowing policy in place and team members felt comfortable raising concerns with the RP or SI team. Team members had weekly conference calls with the area manager and other branch managers throughout the company 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 and they supported the services delivered.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and provides a professional environment suitable for the services it delivers. 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 had recently been refurbished to increase the size of the dispensary and reduce the retail space. The premises were secure, clean, and provided a professional image. There was a well-presented retail area which led to a healthcare counter and dispensary. Pharmacy-only-medicines were stored securely in a locked cabinet on the retail floor. A team member explained the dispensary was no longer screened to allow the pharmacist to see the retail area and keep activity there under constant supervision. The pharmacist could easily intervene in a sale if necessary. Medicines were stored neatly around the perimeter of the dispensary and in drawers. The dispensary was well organised with plenty of work bench space. And it had a sink with access to hot and cold water for professional use and hand washing. Staff facilities were hygienic with access to hot and cold water. The pharmacy had a consultation room that was well advertised, secure and of appropriate size. It also had a second private area for specialist use such as substance misuse supervision. 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 it stores them appropriately. And team members carry out checks to help ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access by a level entrance and a push pad on the door. And it displayed its opening hours and some of the services it provided in the main window. It had a range of healthcare leaflets for people to read or take away. And it advertised services available in the local community such as a travel health clinic. The pharmacy had access to a translator service for people who did not use English as their first language. It purchased medicines and medical devices from recognised suppliers. Medicines were kept in original containers and stored neatly on dispensary shelves and in drawers. Team members carried out checks, such as checking the expiry dates of medicines. And following the process they attached stickers to medicines when they were approaching their expiry date and to highlight and indicate they should be used first. The pharmacy used a well-organised fridge to store medicines and prescriptions awaiting collection that required cold storage. And team members recorded temperatures 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 or a CD by attaching coloured stickers to the outside of the bags of the dispensed medicines. Team members were aware of the risk associated with people in the at-risk group taking valproate-containing medicines and of the Pregnancy Prevention Programme. They always supplied valproate-containing medicines in the manufacturers original packaging. And they supplied Patient Information Leaflets (PILs) and patient cards with every supply. Team members used coloured cards to assist in the counselling of higher-risk medicines such as lithium and methotrexate. The coloured cards were attached to the bag of the dispensed medicines to indicate further counselling was required and on the reverse of the cards there were safety prompts, such as ‘ensure blood monitoring is up to date’ and ‘the same brand must be prescribed’. Team members kept records electronically on the patient medication record (PMR) of advice given. The pharmacy actioned Medicines Healthcare and Regulatory Authority (MHRA) patient safety alerts and medicine recalls on receipt and kept records electronically of action taken. It provided a delivery service and people signed a delivery record to acknowledge receipt of their prescription. Some people received serial prescriptions under the Medicines: Care and Review service (MCR). Team members worked on a monthly 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 people 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 individual medicine, instructions for use and a description of what each medicine looked like. PILs were supplied monthly to ensure people had up-to-date information relating to their medicines.

The pharmacy provided a local NHS substance misuse injection equipment provision service. It provided equipment, as well as advice and information that may be of use. 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 health board and local substance misuse team members. And pharmacy team members received regular refresher training to continue to provide the service safely.

The pharmacy team members were trained to deliver the NHS Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The PIP provided the NHS Pharmacy First Plus service. They treated several common clinical conditions including those affecting the ears, skin and throat. They were supported by other prescribers within the company. The PIP worked to an agreed formulary that listed the medication that could be prescribed, provided supporting information for the prescribers, 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 their medical records were kept up to date.

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 up-to-date written resources available which included the British National Formulary (BNF). And 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 available for use in the consultation room, including a blood pressure monitor and otoscope that was visibly free from wear and tear. The pharmacy had clean CE-stamped cylinders for dispensing liquid medicines and medicine counters for counting some medicines. They had highlighted specific measures to be used solely for the purpose of measuring substance misuse medicines. Prescriptions awaiting collection were stored in a retrieval area and confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevent unauthorised view. And cordless telephones were in use to enable 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.