General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 9 Mill Road, HAMILTON, Lanarkshire, ML3 8AA

Pharmacy reference: 1042551

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

This is a community pharmacy next to a medical practice on the edge of Hamilton town centre. It dispenses NHS prescriptions. And it offers a repeat prescription collection service and a medicines' delivery service. It also 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	Good practice	1.2	Good practice	The pharmacy embeds continuous improvement in its culture. 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.
		1.7	Good practice	The pharmacy has a systematic approach to information governance. It provides regular training. And it carries out regular reviews to confirm that its arrangements meet data protection requirements.
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.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages it services well. The pharmacy team members are organised and efficient. And they provide safe services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team members work to professional standards. They provide safe services and look after people's welfare. The pharmacy keeps records of mistakes when they happen. And the team members are proactive at identifying risks and introducing novel ways of improving its working practices. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members 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 that they listen to people and put things right when they can. The pharmacy encourages people to provide feedback about its services. And they make changes to their processes when they need to.

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 pharmacy used accuracy checking technicians (ACTs) to carry out the final accuracy check. And they knew to follow the procedure that informed them only to check prescriptions that had been annotated by the pharmacist. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacy team signed the dispensing labels to show they had completed a dispensing task. And the pharmacist and the ACT checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacy team members were responsible for recording their errors. And the ACT had been coaching individuals over the past 6 weeks to improve the quantity and quality of their records. For example, they had instructed a team member to take more time when dispensing. And this had reduced the number of errors. The team members had agreed to provide more information about their errors. And this aimed to help them identify new areas for improvement. The ACT made sure that team members read a professional standards newsletter. And they discussed the case studies that were provided. The team members were currently focussed on children's prescriptions. And they knew to record a child's age on a pharmacist information form (PIF) so that it was checked throughout the dispensing process.

The ACT carried out the monthly near-miss review. And they discussed the findings with the team members. The pharmacy's near-miss review records were detailed. And they showed ongoing improvement action. For example, circling the post-code on the prescription bag label to show they carried out identity checks when prescriptions were handed out. And writing the balance of controlled drugs on a PIF to show they had checked the balance. The pharmacy team used the company's list of look-alike sound-alike (LASA) medication to manage dispensing risks. And they used shelf-edge caution labels to highlight LASA stock, such as amlodipine and amitriptyline. The team members recorded LASAs on a PIF when they were processing prescriptions. And a sample PIF highlighted propranolol medication. The ACT identified any near-misses involving LASAs at the monthly review. And they recently confirmed that the initiative had reduced the number of errors. The team members had suggested adding pregabalin/gabapentin to the list. And this was due to the number of errors that were emerging.

The team members were referring to a ‘prescription accuracy tool’ which listed the key points to be checked during the dispensing process. And they were keeping copies of the tool at each work-station. The pharmacist managed the incident reporting process. And the pharmacy team knew when incidents happened and what the cause had been. For example, they knew about two missing tablets. And that the pharmacist had reported the incident to the CDAO. The pharmacy team had discussed the incident. And they had introduced a new measure to manage the risk of it happening again. For example, team members now carried out a stock check when they dispensed a controlled drug. And they recorded that they had done so on the PIF. This aimed to highlight discrepancies and the need for an immediate investigation. The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. And it used a practice leaflet to inform people about the complaints process. The team members issued feedback cards in prescription bags. And they were currently trying to manage expectations around waiting times and telling people how long they might have to wait at the time they handed in their prescriptions.

The pharmacy maintained the legal pharmacy 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 and up to date. The pharmacy team kept the controlled drug registers up to date. And the pharmacist checked and verified the balance of controlled drugs on a weekly basis. 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. The pharmacy provided a delivery service to housebound and vulnerable people. And they made sure that people signed for their medication to confirm receipt. 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 to improve access to medicines and advice. And a sample trimethoprim patient group direction was valid until November 2019.

The pharmacy displayed a notice which provided people with information about its data protection arrangements. And it provided assurance that it protected people's privacy and confidentiality. The pharmacy trained its team members on a regular basis to comply with data protection arrangements. And they knew how to protect people's privacy and confidentiality. The pharmacy separated confidential waste. And placed it into designated bags for off-site shredding. The pharmacy archived spent records for the standard retention period. The protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. And the company had registered the pharmacists with the scheme. The pharmacy trained the team members to comply with safeguarding arrangements. And it provided contact details so that they knew who to contact if they had a concern about a child or an adult. The team members recognised the signs and symptoms of abuse and neglect. And they knew when to refer to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training and protected learning time in the work-place. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced significant growth in the number of NHS items it dispensed over the past year. The pharmacy team had changed over the past few months with people leaving and moving to other branches. And, the pharmacy continued to make changes so it had the right number of team members throughout the week. For example, it had appointed a full-time accuracy checking technician (ACT) to replace a part-time team member. And it was about to appoint a new dispenser to replace a dispenser who had left. The Saturday opening hours at nearby Boots branches had been recently reduced from all-day opening to half-day opening. And the team members that normally worked in the afternoon were working at the branch. The non-pharmacist manager had arranged a meeting out-of-hours about the service changes. And the team members had agreed to new ways of working to manage the increased demand on services. Such as changing the start of the working day from 6.00am to 8.00am so that more team members were available at the end of the day. And more than doubling the number of items that the pharmacy sent for dispensing at an off-site hub.

The pharmacy managed annual leave. And it allowed only one team member to take leave at the one time. The pharmacy manager used rotas. And this ensured that the right number of suitably qualified team members were on duty throughout the week. The pharmacy team members were well-established. And they were experienced and knowledgeable in their roles. The pharmacy kept the team's qualifications on-site. And the following team members were in post; one full-time pharmacist, two part-time pharmacists, 1 full-time accuracy checking technician (ACT), one full-time dispenser (non-pharmacist manager), three full-time dispensers, two part-time dispensers and two Saturday assistants.

The manager carried out annual performance reviews to identify areas for improvement and personal development. And they were in discussion with dispensers to increase the number of pharmacy technicians at the pharmacy. The company provided a range of training resources. And the team members were up-to-date with mandatory training requirements. For example, they had recently completed information governance and safeguarding training. The company was about to introduce a new on-line developmental tool. And the team members would be expected to log-on to the system and answer questions to ensure they continued to be competent in their roles and responsibilities. The manager allocated protected learning time throughout the week. For example, those on NVQ programmes were allocated between one to two hours each week. And time was provided for specific training such as reading standard operating procedures or e-learning. The team members with GPhC registration were expected to attend regular off-site training events at a central location. And they were provided with updates about changes and new services, for example, new 'patient safety' initiatives.

The pharmacy used performance targets. And the team members were focussed on implementing initiatives to support people with their medicines, and to help them better manage their workload. For example, they were registering people with managed repeat dispensing schemes when appropriate. And informing people about its prescription texting service that informed people that their prescriptions were ready for collection. The pharmacy used the service to remind people when their next repeat prescription was due. And this helped them to manage people's expectations and minimise negative feedback and complaints. The team members did not feel undue pressure to increase services. And knew only to recommend services that would be beneficial to people.

The team members felt empowered to raise concerns and provide suggestions for improvement. For example, the manager had submitted a business case to employ an extra 26 hours of dispenser time. And this had been approved. The manager had also asked for extra support due to the service changes. And an extra non-pharmacist manager was working at the pharmacy at the time of the inspection.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A large well-kept waiting area presented a professional image to the public. The pharmacy provided seating and healthcare information leaflets for self-selection. The dispensary was large. And the team members had allocated areas and benches for the different dispensing tasks. For example, they dispensed prescriptions that were being waited on next to the waiting area. And they used dispensing benches at the back of the pharmacy for routine prescriptions. The pharmacy had a separate rear area. And the team members used it for dispensing methadone, or for keeping prescriptions awaiting stock. The pharmacist supervised the medicines counter from the front checking bench. And could make interventions when needed. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room and separate booth. And both were professional in appearance.

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 a step free entrance. And an automatic door provided extra support for people with mobility difficulties. The pharmacy displayed its opening hours in the window. And it displayed healthcare information leaflets in the waiting area and in the consultation room. The dispensing benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process.

The team members dispensed prescriptions for many people who wanted to wait. And this was due to the pharmacy being located next-door to a medical practice. The team members sent prescriptions to an off-site dispensing hub. And they had been recently authorised to double the number of prescription items to help them manage their work-load. The pharmacy had trained the team members to follow the new dispensing process. And they had shadowed colleagues if extra support was needed. The team members retained the prescriptions in a separate cabinet once they had processed them. And on receipt of the dispensed items they filed the prescriptions in the retrieval system and put the prescription bags onto the shelves awaiting collection. The pharmacy team members dispensed methadone doses once a week for the following week for around 20 people. And they obtained an accuracy check at the time of dispensing and again at the time of supply to ensure doses were in accordance with their prescription. The team members kept the doses in the controlled drug cabinet. And they kept sugar-free and sugar-containing methadone in separate cabinets.

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 the pharmacy shelves neat and tidy. And they kept controlled drugs in four well-organised cabinets to manage the risk of dispensing incidents. The pharmacy purchased medicines and medical devices from recognised suppliers. And the team members carried out regular stock management activities, highlighting short dated stock and part-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperatures had remained between two and eight degrees Celsius. The pharmacy used a fridge for insulin and a second fridge for all other items. The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And recorded the outcome, and the date they checked for affected stock. For example, they had checked for folic acid medication in November 2019 with no stock found. The pharmacy had not implemented the Falsified Medicines Directive (FMD). And the pharmacy team did not know about the initiative, or when it was due to be introduced. The pharmacy team had learned about the valproate pregnancy protection programme. And they knew

about the initiative and where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to confirm that people had been provided with safety messages. The pharmacy had not received any new prescriptions since it carried out an audit one year ago.

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 with elastic bands, 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 used a portable phone. And they took 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.