General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 6 Neilston Road, PAISLEY, Renfrewshire, PA2 6LN

Pharmacy reference: 1042932

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

This is a community pharmacy on a main street in the town of Paisley in Renfrewshire. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. The pharmacy provides medicines in multi-compartment compliance packs to people who need help to take their medicines at the right times and it offers a delivery service. Team members provide advice on minor ailments and 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 appropriately 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 mitigate the risk of 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 support them working safely and effectively. SOPs were accessed on an online platform and each team member had individual training records. These included SOPs about the responsible pharmacist (RP) regulations and assembling medicines in multi-compartment compliance packs. SOPs were reviewed by the superintendent pharmacist (SI) team at head office every two years. Notification of new or updated SOPs were communicated to team members via email. Team members read the SOPs and then they completed a competency assessment to show they had understood them. The pharmacy employed an accuracy checking pharmacy technician (ACPT) who followed a procedure for conducting final accuracy checks and knew to only check prescriptions that had been clinically checked and annotated by a pharmacist. Team members were aware of their roles and responsibilities within the pharmacy. They were observed providing advice to people in person and on the telephone within their competence and referring to the pharmacist when necessary. And they accurately described what activities they could and couldn't undertake in the absence of the RP. There was an emergency cascade in place to address any disruption to services or unexpected closure.

A signature audit trail on medicines labels showing who had dispensed and checked each medicine during the dispensing process. This allowed the RP or ACPT to help team members learn from dispensing mistakes identified within the pharmacy, known as near misses. Team members were encouraged to record the near miss on an online system at the time as a method of reflection following a mistake. And they included details such as the time and date the near miss happened, and any contributing factors. Mistakes identified after a person had received their prescription, known as dispensing incidents, were recorded on an online system then reviewed by the SI team at head office. The pharmacy had a patient safety champion who conducted a patient safety review on near misses and dispensing incidents once a month, to identify any trends in mistakes. Team members discussed the findings from the patient safety review and agreed changes they then put in place to manage the risk of the same or a similar mistake happening again. This included circling the quantity of medicines supplied on the medicines labels due to a trend identified with quantity errors. And medicines boxes that had been opened were clearly marked to indicate it did not contain the quantity printed on the medicine box. Team members kept paper-based records of the patient safety review and included details of positive changes that had happened over the month. For example, team members had increased their efforts to ensure all near misses were recorded in a timely manner and the patient safety champion acknowledged an increase in the recording of near misses.

The pharmacy had a complaints procedure and welcomed feedback. There was a quick response (QR) code available on the healthcare counter to allow people to submit feedback about the service they had received. The customer care team at head office shared the feedback received with the pharmacy

manager who would take further action if required. Team members were comfortable managing complains and aimed to do so informally. However, if they could not resolve the complaint, they would provide contact details or the customer care team or SI team.

The pharmacy had current professional public and products liability insurance. It displayed an RP notice that was visible in the retail area and reflected the correct details of the RP on duty, and the paper-based RP log was complete. Team members maintained paper-based controlled drug (CD) registers. And they checked the physical quantity in stock matched the balances recorded in the registers weekly. A random balance check on the physical quantity of two CDs were correct against the balances recorded in the registers. The pharmacy had records of CDs people had returned for safe disposal. Private prescriptions records held electronically were up to date. There was a small number of records relating to unlicensed medicines, but details of supply were not always included to provide an audit trail. This was discussed at the time of inspection and the RP and pharmacy manager provided assurances they would record details in the future.

The pharmacy displayed a privacy notice, chaperone policy and the consultation room was advertised as a safe space. Team members knew how to protect people's confidential information. They had completed online training relating to Information Governance (IG) and the safeguarding of vulnerable people. Confidential waste was segregated and collected by a third-party contractor to be securely destroyed off-site. Team members provided examples of signs that would raise concerns and of interventions they had made to protect vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary skills and knowledge 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 professional concerns, should they need to.

Inspector's evidence

The pharmacy employed one full-time accuracy checking pharmacy technician (ACPT) who also had the role of store manager, one part-time regular pharmacist who was part of the company's relief team, locum pharmacists who provided cover on one day throughout the week, two part-time dispensers and three part-time trainee dispensers. A member of the team had commenced employment as a part-time trainee dispenser the week prior to inspection and was currently undertaking their induction. The pharmacy provided a delivery service. Delivery drivers were organised by the company, they planned their route in advance, and they used an electronic handheld device to record the delivery of each prescription. Team members were observed managing the workload well and they provided support to each other as they worked. The store manager managed annual leave requests to ensure staffing levels remained sufficient to manage the workload safely. Part-time team members provided contingency cover during periods of absence. And the store manager had access to the company's relief team members, should they need it. Team members received appraisals once a year with the manager, to review progress and identify and individual learning needs.

Team members spoken to at the time of inspection undertaking accredited qualification training felt well supported. Protected learning time was provided for accredited qualification training and for specific learning and development. For example, team members provided an NHS injection equipment provision service. And the RP had arranged refresher training for team members. The pharmacy manager attended weekly conference calls with other store managers within the company to receive relevant updates and raise any concerns. This provided an opportunity for professional learning and peer review. The store manager communicated relevant information discussed on the conference call to team members during informal team meetings. Information discussed included priorities for the week and targets set by the company. Team members felt targets were relevant to the services they provided and they did not feel under pressure to achieve them. The pharmacy had a close working relationship with the local GP practice. The RP and store manager had attended a practice meeting to discuss ways to improve partnership working. They had agreed on a new process for submitting repeat prescription requests to the GP practice to make the process more efficient.

There was a whistle blowing policy in place and team members explained they would feel comfortable raising concerns with the RP or pharmacy manager. Team members asked appropriate questions when selling over-the-counter medicines. And they described how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines, by referring the to the RP for supportive discussions.

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.

Inspector's evidence

The pharmacy premises were clean, secure, and provided a professional appearance. There was a small well-presented retail area with one chair for people waiting that led to a healthcare counter and dispensary. The healthcare counter acted as a barrier to prevent unauthorised access to restricted areas of the pharmacy. The dispensary was laid out in a way that allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. It was small with limited workbench space, but it was well organised and team members managed the space well. The dispensary was comprised of two areas, one area was used for the dispensing and checking of prescriptions and the second area was used for the assembly and storage of multi-compartment compliance packs and the dispensing of substance misuse medicines. The dispensary had a sink with access to hot and cold water for professional use and hand washing. Medicines were mostly stored neatly on shelves around the perimeter of the dispensary. Staff facilities were small but clean and hygienic with access to hot and cold water. Lighting and temperature were kept to an appropriate level throughout the premises. The pharmacy had a consultation room that was clearly advertised, lockable, of adequate-size and fit for use.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely and effectively. And they make them accessible to people. The pharmacy suitably sources its medicines from recognised suppliers, and it mostly stores them appropriately. And team members carry out the appropriate checks to help ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access by means of a push pad on the front window that opened the front door automatically. It advertised its opening hours in the main window. And information about services available in the local community such as contacting a midwife. Pharmacy team members had the facilities to provide large print labels to help people with visual impairments take their medicines safely. And they had access to a telephone translator service to support people who were hard of hearing and those who did not use English as their first language. The pharmacy used one well-organised fridge to store its medicines and prescriptions awaiting collection that required cold storage. And team members recorded the temperatures daily with records showing the fridge was operating within the recommended limits of between 2 and 8 degrees Celsius. The pharmacy purchased medicines and medical devices from recognised suppliers. And it mostly stored them neatly on shelves in the manufacturers original packaging. But at the time of inspection a higher-risk medicine was stored out with the manufacturers original packaging in a medicine bottle. A handwritten label attached to the outside of the bottle showed what medicine should be contained inside, but a batch number or expiry date were not recorded. The importance of batch numbers being recorded should the medicine be identified in a Medicines Healthcare and Regulatory Agency (MHRA) product recall or patient safety alert was discussed at the time of inspection. Team members checked the expiry dates of medicines and recorded their actions on a date checking matrix. And they attached coloured stickers to the boxes of medicines with a shorter expiry date to indicate it should be used first. Records seen showed date checking was up to date and a sample of 20 medicines showed none had expired.

Team members used baskets during the dispensing process to separate people's prescriptions and to prevent medicines from becoming mixed-up. They used a handheld electronic device to scan a barcode on the person's prescription bag before handing it out to people. The handheld device prompted team members to provide advice and to complete a set of patient-safety questions before handing out. This included for higher-risk medicines such as warfarin or methotrexate, with questions such as when their last blood test was. The handheld device also alerted team members if the prescription contained a fridge line or a CD. Team members were aware of the Pregnancy Prevention Programme and the risks associated with valproate-containing medicines. They always supplied valproate in the manufacturers original packaging and provided patient information leaflets (PILs) with each supply. They currently had no people receiving valproate-containing medicines in the at-risk category. The pharmacy received MHRA patient safety alerts and product recalls via email and team members actioned these on receipt. They kept paper-based records of action taken and records seen included a signature audit trail for future reference. Some people received serial prescriptions under the Medicines:Care and Review service. Team members prepared prescriptions in advance of people's expected collection dates. And they kept records each supply and expected collection dates. This helped manage workload within the pharmacy and allowed the pharmacist to identify any issues with people not taking their medicines as they should. The pharmacy provided a text message service to alert people their prescription was ready

to be collected. They obtained consent for this service and kept records of this on the patient medication record (PMR).

The pharmacy provided medicines in multi-compartment compliance packs when requested to help people take their medicines properly. Team members managed this workload 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 recorded any changes to people's medication in a communications book, for example if a medicines strength was increased or decreased. And they kept a copy of this with the master sheet. Team members attached dispensing labels to each person's pack which included warning labels for each medicine, directions for use and a description of what each medicine looked like. They included patient information leaflets (PILs) every month to ensure people had up to date information relating to their medicines.

The pharmacy provided a local NHS injection equipment provision service. This included providing equipment, as well as advice and information that may be of use. Team members were trained to ask the appropriate questions. And the kept non-identifiable information by using reference numbers on an online platform. They were supported by local substance misuse colleagues. Team members were trained to provide the NHS Pharmacy First service within their competence and under the supervision of a pharmacist. Team members used consultation forms to record relevant information before referring to the pharmacist for treatment. The pharmacist provided treatment for common conditions such as skin infections and urinary tract infections under a Patient Group Direction (PGD). The pharmacy kept well-organised paper-based records of treatment provided and referral decisions. And they communicated these to people's GPs to ensure their medical records were kept up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the 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 internet services to allow team members to obtain up-to-date resources and guidelines to support them in their roles. This included the British National Formulary (BNF) and local health board formulary.

The pharmacy had a set of clean CE-stamped cylinders and tablet counters that were fit for use. Some cylinders were highlighted to be used for specific medicines only, for example substance misuse liquid medicines and children's medicines. Team members used a manual dispensing pump for dispensing substance misuse liquid medicines. They had the first doses checked by a pharmacist to ensure it measured accurate doses. And it was cleaned after each use.

Prescriptions awaiting collection were stored in drawers behind the health care 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. There were two telephones in use within the pharmacy. One was cordless and was used for private conversations.

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.