General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 44-46 Victoria Street, NEWTON STEWART, Wigtownshire, DG8 6BT

Pharmacy reference: 1043036

Type of pharmacy: Community

Date of inspection: 01/06/2023

Pharmacy context

This is a community pharmacy on a parade of shops in the village of Newton Stewart, Wigtownshire. It dispenses NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy provides a range of services including a home delivery service and the NHS Pharmacy First service. It also dispenses some medicines in multi-compartment compliance packs to people who need this level of support.

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	1.2	Good practice	The pharmacy team is good at recording and reviewing mistakes made during the dispensing process. It uses these reviews to learn from its mistakes and improve the safety of its dispensing process.
		1.8	Good practice	The pharmacy team is well equipped to safeguard vulnerable adults and children and it can demonstrate examples of where it has raised a concern and appropriately supported people.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting the pharmacy team members to develop their knowledge and skills, and it encourages their professional development.
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 has a robust process to review mistakes made during the dispensing process. The pharmacy team is good at using these reviews to learn and improve the safety of its dispensing process. The pharmacy proactively encourages people who use the pharmacy to feedback on the service they receive. The pharmacy team is well equipped to safeguard vulnerable adults and children and it can demonstrate examples of where it has raised a concern and appropriately support people. The pharmacy keeps the records it needs to by law and keeps people's confidential information secure.

Inspector's evidence

The pharmacy had a set of electronically held standard operating procedures (SOPs). These were instructions designed to help the team undertake various processes safely. There were SOPs for the management of controlled drugs (CDs) and dispensing prescriptions. Team members were able to access the SOPs through their own personal smartphones or tablets at any time. Team members read the SOPs periodically and they completed a short quiz to assess their knowledge and understanding of an SOP. The pharmacy's accuracy checking technician (ACT) was also the pharmacy's manager and had visibility of each team members progress record. This helped the ACT check if a team member had not yet read an SOP that was relevant to their role. The ACT demonstrated that all team members had read and understood the SOPs and had passed the relevant quizzes. The ACT was trained to undertake a final accuracy check of prescriptions. The pharmacy had a written procedure in place that clearly described the role and responsibilities of the ACT. The ACT and the responsible pharmacist (RP) annotated prescriptions which created a visual confirmation that the prescriptions had been accuracy and clinically checked. The ACT ensured they only checked prescriptions that were annotated by the RP.

The pharmacy had a procedure for the team to follow to highlight and record details of mistakes that were made during the dispensing process but spotted by the RP during the final checking stage. These mistakes were known as near misses. The team members recorded near misses on paper as they found this easier than using an electronic record. Each team member had their own personal near miss log. This helped them take responsibility for the mistakes they made. Details recorded included the date, time, a brief description of the near miss and any actions taken to prevent a similar mistake happening again. The pharmacy had appointed a 'patient safety champion' (PSC) who was a senior team member. The PSC's responsibility was to assess the near miss record each month and identify if there were any patterns or trends. The PSC then held discussions with the team around how they could improve, and with each individual team member on a one-to-one basis. The findings of the team discussions were displayed in the dispensary. Team members were encouraged to take the time to refer to the notice board so they could all learn from the information displayed. Most recently, team members had discussed a series of near misses where the incorrect quantity of a medicine had been dispensed. They had decided to ensure they highlighted the quantity on prescriptions if the quantity to be dispensed was not a common quantity. Previously, team members had also decided to separate some medicines on the dispensary shelves to reduce the risk of them being dispensed in error. For example, medicines that had similar names or similar packaging.

The pharmacy used an electronic system to record and report dispensing errors which had reached people. Team members discussed these errors and made changes to reduce the risk of them happening again. A team member was required to complete an incident report form within 24 hours of the

incident. Following an incident involving a CD, the team had decided to check the balance of the CD in the CD register before a CD was supplied to a person. rather than after the supply of the CD.

The pharmacy had a procedure in place to support the handling of complaints or feedback from people who used the pharmacy. Team members explained they normally attempted to collect feedback and resolve any complaints from people verbally. If they were unable to resolve a complaint it was referred to the ACT. If the ACT was unable to resolve the complaint, the person was signposted to the pharmacy's head office team. The details of how people could make a complaint was outlined on the back of any till receipts provided to people. Team members invited people to complete an online survey to rate the service they had received. The ACT had oversight of every survey completed and comments made. The ACT demonstrated many comments the pharmacy had received from people, and they were mostly positive.

The pharmacy had professional indemnity insurance. It was displaying the correct RP notice. The RP register had been completed correctly. The pharmacy kept appropriate private prescription records. The pharmacy maintained controlled drug (CD) registers. And the team kept them in line with legal requirements. The team completed weekly balance checks of the CDs. The balance of a randomly selected CD was checked and was correct. The pharmacy kept records of CDs returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The pharmacy displayed a privacy notice and how it managed people's confidential data. The team separated confidential waste from general waste and it was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information and they had all completed training about the General Data Protection Regulation (GDPR). The pharmacy had a written procedure to help the team raise concerns about safeguarding vulnerable adults and children. And team members, including the RP, had completed internal training on the subject. The RP was registered with the Protecting Vulnerable Groups (PVG) scheme. Team members described a recent incident where the team had raised concerns about a vulnerable person and how the matter had been handled appropriately. The team kept a record of the incident.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a suitably skilled team to manage its workload. It is good at supporting the pharmacy team members to develop their knowledge and skill, and it encourages their professional development. Team members support each other and work well together to provide an efficient service. And they can provide feedback and raise concerns where necessary.

Inspector's evidence

At the time of the inspection the RP was a locum pharmacist. The pharmacy had not had an employed pharmacist for several months. But the RP had been working at the pharmacy each day since September 2022. The team felt this had given the pharmacy more stability. The pharmacy had continued to advertise for a full-time pharmacist. During the inspection the RP was supported by two full-time qualified pharmacy technicians, a full-time trainee pharmacy assistant and a part-time trainee pharmacy assistant. The pharmacy also employed a part-time pharmacy assistant and a part-time delivery driver who were not present during the inspection. Team members covered each other's planned and unplanned absences, and they were able to request for additional dispenser support from the pharmacy's area manager if they felt the need to do so. Team members explained they were comfortable in their roles and felt the pharmacy benefited from good leadership. They were observed managing the workload well and supporting each other as they worked.

The pharmacy supported its team members to keep their knowledge and skills up to date using an internal electronic training system. The company's head office periodically provided the team with mandatory modules to complete. These included modules on health and safety, and new over-the-counter medicines the pharmacy was selling. Team members were also able to voluntarily select modules to complete. Several team members had recently decided to complete training on seasonal conditions, for example hay fever, to help them support people manage their condition in the upcoming summer months. Team members received protected time to complete their training. This helped them train without any distractions. The pharmacy had an appraisal process to support team members with their development. These were a formal conversation between the team member and the ACT and included any goals to be achieved. One team member had recently requested to be enrolled onto a pharmacy technician course, which was granted.

The team held several meetings throughout the working week. These meetings were an opportunity for the team to discuss patient safety, tasks to complete, raise professional concerns and provide feedback on how the pharmacy could improve service delivery. The team was provided with a 'professional standards bulletin'. The bulletin informed the team of patient safety incidents that had occurred in other pharmacies within the company and encouraged the team to discuss the incidents and find ways of reducing the risk of the incidents happening with the pharmacy. Team members signed and dated the bulletin to confirm they had read and understood its contents.

The team was set some targets to achieve by the company. These included the number of prescription items dispensed and the number of service consultations completed. Team members agreed that the targets were generally achievable, and they were not under any significant pressure to meet them. They explained they always used their professional judgment to only offer services to people who needed them and their primary focus was to provide a safe and efficient service to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are well maintained and suitable for the services provided. The pharmacy has a suitably private consultation room where people can have a confidential conversation with a pharmacy team member.

Inspector's evidence

The pharmacy premises were clean, hygienic and well maintained. The dispensary was of a suitable size to manage the dispensing workload and there was ample space to store medicines. The benches used by team members to dispense medicines were spacious and kept organised throughout the inspection. Floor spaces were kept clear to prevent the risk of trips or falls. The pharmacy had a suitable, private consultation room to support team members to have confidential conversations with people.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services that are managed safely and effectively. And it makes its services accessible to people. The pharmacy correctly stores and sources its medicines and the pharmacy team completes regular checks to identify any medicines which are close to expiring or are out of date to make sure the medicines it supplies are of a suitable quality.

Inspector's evidence

There was a small step into the pharmacy from the street. The pharmacy had a portable ramp to support people with wheelchairs or prams to enter the pharmacy. There was a doorbell people could use to get the attention of a team member if they needed support at the entrance door. There was a push button automatic door to further support people to enter the pharmacy. The pharmacy had a facility to provide large-print labels to people with a visual impairment and there was a hearing loop to help people with a hearing impairment. The pharmacy had a small selection of healthcare related information leaflets for people to take away with them.

Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply and had recently completed an audit of valproate patients to highlight any people the pharmacy supplied valproate to who may be at risk. The pharmacy team used laminated alert cards to highlight other high-risk medicine prescriptions that may require further intervention from the RP.

Team members used dispensing baskets to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. Team members placed laminated alert cards into the baskets to highlight to the RP that there may be the need for additional counselling. They also used pharmacist information forms (PIFs) which they could annotate to provide the RP with any additional information. For example, if the person suffered from any allergies. Team members had recently discussed increasing their use of PIFs. This was to reduce the risk of them forgetting to verbally inform the pharmacist of important information. Team members signed dispensing labels to maintain an audit trail. The audit trail helped to identify which team member had dispensed the medicine and which team member had completed the final check. And they used a ‘quad stamp’ for team members to sign when the prescription had been dispensed, clinically checked, accuracy checked and then handed out.

The pharmacy supplied some people with their medicines dispensed into multi-compartment compliance packs. These packs were designed to help people take their medicines at the right times. There were ‘master-sheets’ which team members used to cross-reference with prescriptions to make sure prescriptions were accurate before the dispensing process began. If they spotted a discrepancy, for example, if a medicine was missing from the prescription, they made enquires with the prescriber. Team members annotated the master sheets with details of authorised changes to people’s treatment. For example, if a treatment had been stopped. They included the details of the person who had authorised the change, for example, the person’s GP. People were supplied with patient information

leaflets and visual descriptions of each medicine to help people identify the contents. For example, square, green, tablet. The pharmacy kept records of the delivery service which they used to manage any queries.

The pharmacy stored pharmacy-only (P) medicines directly behind the pharmacy counter. The pharmacy had a process for the team to check the expiry dates of the pharmacy's medicines. The team demonstrated that it was up to date with the process. No out-of-date medicines were found by the inspector following a check of approximately 30 randomly selected medicines. The pharmacy had a medical grade fridge to store medicines that required cold storage. And the team kept records of its minimum and maximum temperature ranges. A sample of the records was seen which showed the fridge was operating within the correct ranges. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy received medicine alerts electronically through email and the company intranet. The team actioned the alert and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the correct equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including hard copies of the British National Formulary (BNF) and the BNF for children. The pharmacy used a range of measuring cylinders. There were separate cylinders to be used only for dispensing water. This helped reduce the risk of contamination.

The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.