General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 26-30 George Street, BATHGATE, West Lothian, EH48 1PW

Pharmacy reference: 1043047

Type of pharmacy: Community

Date of inspection: 23/11/2022

Pharmacy context

This is a mid-sized community pharmacy in Bathgate town centre. The pharmacy provides a range of services including dispensing private and NHS prescriptions. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a range of other services, including a prescription collection service and the NHS Pharmacy First service. It also supplies medicines for its substance misuse 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	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 has written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's private information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy had felt the pressures of a heavier workload during and since the pandemic. It had experienced a reduction in staff numbers alongside an increase in prescriptions. And in recent weeks it had an additional increase in prescriptions. This was due to the unexpected temporary closure of pharmacies nearby. So, the pharmacy had reduced its other services so that it could concentrate on delivering a safe and effective prescription service. But, when the workload allowed, pharmacists continued to provide medicines under patient group direction (PGD). They did this so they could treat a greater range of conditions more effectively without people having to go to their GP.

The team used an electronic system for recording its 'near miss' mistakes and errors. But its near miss records did not contain much detail. And they had not been reviewed as part of the pharmacy's monthly patient safety review process for five months. Team members described how pharmacists and the manager, who was an accuracy checking technician (ACT) highlighted and discussed 'near misses' and errors with them as soon as they were discovered. This enabled the team to reflect and learn. The inspector and ACT manager discussed the importance of recording what the team had learned from its mistakes and any actions arising from them. They discussed how this would provide more information for patient safety reviews. And it would help the team learn and continually improve. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help them avoid making a similar mistake again. But although the team had not kept full records of its near misses it was clear that the team had taken steps to reduce the risk of repeating them. Team members described how they triple checked medicines which looked alike and whose names sounded alike (LASA). And they spoke the name of the medicine out loud to one another to reduce the chance of dispensing the wrong one. The pharmacy also received a regular monthly newsletter from the superintendent. The newsletter highlighted areas of risk. And each month it identified common errors and ways to prevent them. It also provided educational information on a selected treatment or condition.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to follow. The SOPs were available on the Boots 'hub' application which team members had on their smart phones. Team members had read the SOPs relevant to their roles. And they had completed a quiz for each one to test their knowledge and understanding. They appeared to understand their roles and responsibilities and were seen consulting the pharmacist when they needed his advice and expertise. This was observed when the pre-registration technician was seen to supervise people taking their daily dose of medicine after checking it with the RP and getting his authorisation. The RP had placed his RP notice on display where it could be seen by people. The notice showed his name and registration number as required by law.

The pharmacy invited people to give feedback on the quality of its services. Each till receipt had information on the back for people to report their experience of how they had been treated at the pharmacy. People also gave feedback directly to team members, or they could pick up a customer comment card at the counter. The pharmacy team knew how to provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. During the inspection someone was unhappy that their prescription had not arrived. They had almost run out of their medicines. So, the team arranged with the surgery it to be available for the next day. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for people using the pharmacy's services.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register, its RP record and its private prescription records. And it had a CD destruction register for patient-returned medicines which was up to date. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy did not have records for emergency supplies requested by people, as it didn’t make any. But its records for emergency supplies requested by prescribers were in order. The pharmacy also had the appropriate records for supplies made under the NHS Pharmacy First service, the NHS ‘Medicines Care Review’ (MCR) service and serial prescriptions. It was clear that the team knew the importance of ensuring that all the pharmacy’s essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They discarded confidential paper waste into separate waste bags. And a licensed waste contractor collected the bags each week for safe destruction. The pharmacy kept people’s personal information, including their prescription details, out of public view. And it had a safeguarding policy to support vulnerable people. Team members had completed appropriate safeguarding training. And they understood their safeguarding responsibilities. And they reported any concerns to social services, the police or a person’s GP as appropriate. The team accessed details for the relevant authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has measures in place to help ensure it manages its workload safely. And its team members support one another. They are comfortable about providing feedback. And they make suggestions so that they can improve the quality of the pharmacy's services. Team members have the right skills and training. But they struggle at times to manage the workload and deliver the prescription service efficiently.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The pharmacy did not currently have a regular responsible pharmacist (RP). And so, pharmacist cover was provided by locums and relief pharmacists. The RP on the day of the inspection was a relief pharmacist who currently worked part-time at the pharmacy. The pharmacy also had two other part-time RPs. And the three RPs covered the pharmacy's opening hours between them. Other team members present included the pre-registration technician and a trainee pharmacy adviser (PA). The PA role provided the team member with dispensing assistant training and medicines counter assistant training. The store manager, who was also an accredited checking technician (ACT), was also present.

The pharmacy was behind with its overall workload. It had two days' worth of prescriptions to be dispensed. And it also had a backlog of dispensed prescriptions waiting to be checked. The team worked hard to keep on top of its dispensing tasks. At the same time, it helped people waiting for prescriptions or advice. There was a continuous queue of people at the dispensary reception. The pre-registration technician focused on producing labels and ordering stock for the two-day backlog. But neither the pharmacist nor the ACT had the opportunity to deal with the backlog of dispensed prescriptions waiting to be checked during the inspection. There were prescriptions that were not ready for people when they came to collect them. And these had to be dispensed and or checked whilst people waited. And so, it was clear that although the team managed the immediate workload sufficiently, it was under pressure to do so. And it was having difficulty in managing all its tasks in a timely way. But staff described feeling supported in their work by their colleagues. And overall, they were seen to work effectively with one another. They had raised concerns about staff numbers and workload to their line managers. But it was reported the pharmacy had difficulty recruiting and retaining staff. And the team felt that this was a problem shared by other pharmacies in the area. Team members discussed issues as they worked. And the pharmacist made day-to-day professional decisions in the interest of people. And while he felt the pressures of such a busy prescription service, he was not put under pressure to meet any business targets. The team had not had any reviews about their work performance recently. But they discussed issues as they worked. When time, they kept their knowledge up to date through regular online e-learning training modules.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they provide an adequate amount of space for those services. The pharmacy is sufficiently clean and secure. The team keeps its workspace and storage areas appropriately tidy and organised.

Inspector's evidence

The pharmacy had a relatively spacious retail area which occupied one floor. It had a consultation room and a waiting area. The pharmacy had screens on top of its counter and at the prescription reception counter to help protect people from the transfer of infections. The team cleaned the pharmacy's work surfaces and contact points daily. And it generally kept the premises tidy and organised. But it did not have much free worksurface due to a build-up of prescriptions in baskets waiting to be checked. And the floor had some dust and debris around its edges.

The pharmacy had a long pharmacy counter running alongside the dispensary. It kept its pharmacy medicines behind the counter. The dispensary had a customer-facing countertop where people could hand in or collect their prescriptions. And the countertop had several workstations beneath it. The pharmacist used one of the workstations to carry out clinical and accuracy checks on prescriptions. And he also counselled people appropriately and gave them advice here. The countertop had screens along it which prevented people from seeing prescriptions on the bench below.

Alongside the customer-facing workstations the dispensary had a 'U' shaped area. This provided a more secluded area where staff could work with fewer interruptions from people. The pharmacist was observed checking some prescriptions here. And he did so without being disturbed. The U-shaped area had workbenches along three sides with storage areas above and below. The dispensary also had a run of pull-out drawers and shelves for storing medicines and completed prescriptions awaiting collection. Dispensed items and prescriptions were stored so that people's information was kept out of view. The consultation room was close to the dispensary. And the team locked it after use. The pharmacy had a second floor which had a stock room. And a room for dispensing multi-compartment compliance packs.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures help ensure it provides its services safely. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use and protect people's health and wellbeing. The pharmacy team supplies medicines with information that people need. So they can take their medicines properly and safely.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access and two sets of double automatic doors. And the team kept the retail area relatively free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it also ordered some people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help avoid errors.

The pharmacy provided medicines in multi-compartment compliance packs for people who needed them. The pharmacy's labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. The pharmacy also supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And it labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. The pharmacy organised its compliance pack service in accordance with a rolling four-week cycle. And it had a system for adjusting its supplies for any mid-cycle prescription changes. And any changes made after a person was discharged from hospital.

The RP gave people advice on a range of matters. And he explained how he gave the appropriate advice to anyone taking higher-risk medicines. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This did not currently include people in the at-risk group. But the RP described the counselling he would give when supplying the medicine to any people in the at-risk group to ensure they were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy had supplies of the appropriate patient cards and information leaflets and knew to supply these each time.

The pharmacy offered the NHS Scotland 'Pharmacy First' service. Where people could obtain medicines for a range of minor ailments and conditions. Several team members had been trained to supply medicines for a small range of conditions. And they followed the local health board protocol by supplying medicines from a specified list. The list included medicines such as paracetamol. And threadworm treatments for children. Team members referred to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI) or an ear infection. The RP could supply a selection of prescription medicines under PGD. Besides medicines for UTIs and ear infections these included medicines for impetigo, emergency hormonal contraception and gluten free products.

Some people received medicines from the NHS 'Medicines Care Review' (MCR) serial prescriptions. And the team had a system for monitoring and tracking supplies so that it knew when people were due to

get their medicines. The system also allowed the team to monitor compliance and address any issues. When they had time pharmacists used the pharmacy care record to identify people for review. These were often people on regular repeat prescriptions. They also used the MCR process to identify any care issues, referring people back to their GP where further medical intervention was required. The pharmacy supplied a variety of medicines by instalment. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together. The pharmacy also supplied medicines in an emergency to people by using the NHS Unscheduled Care service. And it used the appropriate form (UCF) to inform their GP.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately. And stock on the shelves was generally tidy and organised. The RP agreed that all medicines should be stored in the manufacturer's original packaging where possible. The pharmacy date-checked its stocks regularly. And it kept records to help the team manage the process effectively. The team also conducted an expiry date check as part of its dispensing process. Short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The team had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room, the compliance pack room and the dispensary. Computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.