General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 12 The Mall, Craigshill, LIVINGSTON, West Lothian, EH54 5ED

Pharmacy reference: 1043071

Type of pharmacy: Community

Date of inspection: 19/08/2024

Pharmacy context

This is a community pharmacy located within in a small shopping centre in the town of Livingston. 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 provides a smoking cessation service and substance misuse service. Pharmacy 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 suitably identifies and manages the risks with the services it provides. And it keeps the records it needs to by law. Pharmacy team members record and discuss dispensing makes and make changes to prevent the same mistake happening again. They understand their role in helping to protect vulnerable people and they suitably protect people's confidential information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) available to its team members to help them work safely and effectively. Most SOPs were accessed electronically but a small number of SOPs were paper-based and stored in a folder. They included SOPs about the absence of a responsible pharmacist (RP) and how to enter prescription data. SOPs were reviewed by the Superintendent Pharmacist (SI) team every two years. And team members completed an online assessment to show they had read and understood them. Notification of new or updated SOPs were communicated to team members via email. The pharmacy employed an accuracy checking pharmacy technician (ACPT) who followed a procedure for conducting final accuracy checks and they knew to only check prescriptions that had been clinically checked and annotated by a pharmacist. Team members described their roles and responsibilities within the pharmacy. And they accurately described what activities they could or couldn't undertake in the absence of the RP. There was a business continuity plan in place to address any disruption to services or unexpected closure.

A signature audit trail on medicines labels showed who had dispensed and checked each medicine. This meant the RP and ACPT were 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 missed happened, and any contributing factors. Team members were encouraged to record the near miss when it happened as a method of reflection following a mistake. Mistakes identified after a person received their prescription, known as dispensing incidents, were recorded on an online system, and then reviewed by the SI team at head office. A patient safety review audit was carried out on near misses and dispensing incidents by the pharmacy technician once a month. Team members then discussed the findings from the audit and agreed actions they put in place to manage the risk of the same or similar mistake happening again. This included separating medicines with similar sounding names or packaging on the shelves to avoid selection errors. And team members now received a second check on all insulin they dispensed due a trend identified in selection errors.

The pharmacy had a complaints procedure and welcomed feedback. There was a quick response (QR) 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 contact details for the customer care team or the SI.

The pharmacy had current professional indemnity and liability insurance. The pharmacy displayed an RP notice which was visible from the retail area and reflected the correct details of the RP on duty, and the paper-based RP log was mostly complete with minor omissions of when the RP ceased duties at the end of the day. Team members maintained paper-based controlled drug (CD) registers. And they checked

the quantity of the physical stock matched the balances recorded in the registers weekly. A random check on the quantity of three CDs were correct. The pharmacy had records of CDs people had returned for safe disposal. Private prescription records held electronically were up to date and mostly complete, but there were some entries with the incorrect prescriber details. This was discussed at the time of inspection. Records relating to the supply of unlicensed medicines were complete.

There was a chaperone policy and data handling notice 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 securely destroyed off-site. Team members understood their role in helping to protect vulnerable people. And they provided examples of signs that would raise concerns and of 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 they need for their roles and the services they provide. They manage the workload well and provide support to each other as they work. And they feel comfortable to raise professional concerns should they need to.

Inspector's evidence

The pharmacy employed one full-time pharmacist, one full-time accuracy checking pharmacy technician (ACPT) who had the role of pharmacy manager, one part-time pharmacy technician, three part-time dispensers and two full-time dispensers, one of which was undertaking an accredited training course. The pharmacy provided a delivery service twice a day. Delivery drivers were organised by the company, they planned their route in advance and they used an electronic 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 pharmacy 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.

Protected learning time was provided for staff undertaking accredited qualification training. And for the introduction of new services or for specific learning and development. For example, team members had received face-to-face training to provide a smoking cessation service. Team members received appraisals annually with the pharmacy manager to review progress and identify any individual learning needs. They asked appropriated questions when selling over-the-counter medicines. And explained how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines, by referring to the RP or person’s GP for supportive discussions. The pharmacy had a close working relationship with the local GP practice. The pharmacy manager and regular pharmacist attended the practice for a meeting every four months. They would discuss relevant updates to services and made suggestions to improve partnership working. The pharmacy manager and GP practice manager had recently agreed on a direct telephone line to improve ways of communicating between the two teams.

Team members were encouraged to make suggestions to improve their ways of working. There was a whistle blowing policy in place and team members explained they would feel comfortable raising concerns with the pharmacy manager or RP. The pharmacy manager had weekly conference calls with 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, they felt these were appropriate for the services they provided and did not feel under pressure to achieve them

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services it provides. They are clean, secure and provide a professional image. There is 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 well-presented retail area which led to a healthcare counter and large dispensary. Pharmacy-only-medicines were stored behind the healthcare counter which acted as a barrier. And the dispensary was laid out in a way so that the pharmacist could intervene in a sale at the medicines counter if required. Medicines were stored neatly around the perimeter of the dispensary and on shelves under work benches. 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 clean and hygienic with access to hold and cold water. The pharmacy had a small consultation room that was well advertised, clean and fit for use. 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 service's 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 ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a push pad that opened an automatic door. It advertised its opening hours and the services it provided in the main window. The pharmacy had a range of healthcare leaflets available for people to read or takeaway. And it advertised services available in the local community such as a stop smoking clinic. Team members had the facilities to provide large-print labels to help people with visual impairments take their medicines safely. And they displayed a poster advertising the NHS Pharmacy First service that was translated to Polish to help support people within the local community who do not use English as their first language. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members checked the expiry dates of medicines and recorded their actions on a date-checking matrix. And they attached stickers to medicine boxes with a shorter expiry date to indicate it should be used first. Records showed date checking was up-to-date and a random selection of 20 medicines showed none had expired. The pharmacy used two well-organised fridges to store its medicines and prescriptions awaiting collection that required cold storage. And team members recorded the temperatures daily with records showing both fridges were 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. 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 associated risks with valproate-containing medicines. They always supplied valproate in the original packaging and included patient information leaflet and patient alert cards with each supply. The pharmacy received Medicines Healthcare and Regulatory Agency (MHRA) product recalls and patient safety alerts via an online system and actioned these on receipt. They kept paper-based records of actions taken for future reference but there was no audit trail to show which member of the team had actioned the recall. Some people received serial prescriptions under the Medicines, Care and Review (MCR) service. Team members prepared prescriptions in advance of people's expected collection dates. And they kept records of each supply and expected collection dates. This allowed them to plan their workload in advance and allowed the pharmacist to identify any potential issues with people not taking their medicines as they should. Team members used the company's offsite hub pharmacy for dispensing some people's prescriptions which helped manage workload within the pharmacy. They entered the prescription details electronically on the patient medication record (PMR), these were clinically and data accuracy checked by the RP before being sent to the hub pharmacy for assembly. Completed prescriptions were returned to the pharmacy within two working days. Team members

made people aware their prescriptions were dispensed at the hub pharmacy, and they kept records electronically on the PMR. 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 them 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 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 team members were trained to deliver the NHS Pharmacy First service within their competence and under the supervision of a pharmacist. The pharmacist provided medicines for common conditions such as urinary tract infections and skin infections under a Patient Group Direction (PGD). Team members used consultation forms to gather information before referring to the pharmacist for treatment. The pharmacy kept well-organised paper-based consultation records to record treatment provided or referral decisions. And team members communicated these to people's GP to ensure their medical records were kept up to date. The pharmacy provided an NHS Stop Smoking service to people in the local community who required support to stop smoking. People could self-refer to the service at the community pharmacy or were referred by the local Quit Your Way service. Team members were trained to ask the appropriate questions and they worked to a service specification and health board formulary which listed medicines that were suitable to be supplied and when referral would be appropriate. They were supported by local health board colleagues and received training on how to monitor carbon monoxide levels. And they kept records of consultations.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Team members have access to the appropriate equipment they need to provide the pharmacy services. And they use them appropriately to keep people's confidential information secure.

Inspector's evidence

The pharmacy had up-to-date written resources which included the British National Formulary (BNF) and the local health board formulary. And they had access to internet services to allow team members to obtain up-to-date information and guidelines to support them in their roles.

The pharmacy had a set of clean CE-stamped cylinders and tablet counters that were fit for use. Team members used a manual dispensing pump for dispensing substance misuse medicines. They cleaned it after each use and had the first doses checked each time to ensure it measured accurate doses. It was calibrated annually by the company to ensure it remained fit for use. Pharmacy team members used a carbon monoxide monitor to support people who required help to stop smoking. It was cleaned regularly and team members used single-use mouth pieces for each person.

Prescriptions awaiting collection were stored in shelves behind the healthcare 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. And cordless telephones were in use to allow 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.