General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Braehead Shopping Centre, Unit Msu3, BRAEHEAD, Renfrewshire, G51 4BP

Pharmacy reference: 1073934

Type of pharmacy: Community

Date of inspection: 11/05/2023

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS and private prescriptions and supplies prescription only medicines via 'patient group directions' (PGDs). Pharmacy team members advise on minor ailments and medicines use and provide over-the-counter medicines.

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

Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. The pharmacy has standard operating procedures to identify and manage risks. Team members mostly follow them, but they need to review procedures for hub dispensing to keep services safe. Team members make records of mistakes. They learn from these mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. The company had recently changed the way it introduced new procedures and now issued them via its online operating system. Team members read the SOPs and annotated records to show they had agreed to follow them. And records showed ‘responsible pharmacist’ and ‘controlled drug’ procedures were up to date. Dispensers signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ prescriptions. This meant the pharmacist and was able to help individuals learn from dispensing mistakes. Team members recorded near miss errors. And they discussed the errors at a monthly team briefing to help them identify and manage dispensing risks. The pharmacy used bar-code scanning technology to identify and manage selection errors. And records showed that ‘incorrect quantity’ was the main cause of near miss errors. Team members had discussed ways to avoid quantity errors and they agreed to obtain an accuracy check from a colleague when they had to split a pack. They also scored packs before putting them back on the shelf to show they did not contain the full quantity as stated on the label. Team members were proactive at managing risks. And they had arranged for a third fridge to be installed due to an increase in prescriptions for medicines that required to be kept between two and eight degrees Celsius. They had also separated omeprazole to manage the risk of capsules being incorrectly supplied against prescriptions for tablets. Team members followed an 'incident reporting' procedure. And they knew to liaise with the relevant team members to ensure they accurately recorded incidents. They used an electronic template which they sent to the superintendent's office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The pharmacy trained its team members to handle complaints. And the company provided a SOP for them to refer to.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. The pharmacy operated with two pharmacists. And one of the pharmacists had completed the record in advance. This meant the record was not contemporaneous record of the RP in charge. Team members maintained the controlled drug registers and kept them up to date. And they evidenced that they carried out a regular balance check. People returned controlled drugs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the pharmacist signed to confirm destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies against private prescriptions and supplies of 'specials’ that were up to date. The pharmacy provided training so that team members understood data protection requirements and knew how to protect people's privacy. They used a designated container to dispose of confidential waste. And

an approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And team members knew to speak to the pharmacist whenever they had cause for concern. The pharmacy had contact details for local agencies for ease of access.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Team members continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The company conducted reviews to confirm the pharmacy had the right number of team members with the necessary knowledge and skills for the services it provided. The pharmacy had experienced recent staffing changes. This included the appointment of a new permanent RP to replace the previous post holder. The pharmacy was also in the process of recruiting for another two full-time pharmacists. And these pharmacists would be employed to provide services from the consultation room. The company had arranged for locum pharmacists to provide dispensary cover in the interim. And the new RP concentrated on providing services from the consultation room. The company had reduced the range of services it offered until the new pharmacists were in post. People accessed and booked services via the pharmacy's online diary. And the pharmacist had control of the diary which enabled them to restrict appointments depending on staffing levels and workload. A full-time experienced non-pharmacist manager supported the RP. They had achieved a dispenser qualification, and this meant they also provided dispensing support when required. The pharmacy called on team members from nearby branches when there were staffing shortages. And part-time team members also increased their hours to provide cover. This helped to avoid disruptions and provided service continuity. The pharmacy used a rota system to cover its extended opening hours. And it ensured more team members were on duty on Thursdays and Fridays when the pharmacy was at its busiest.

The pharmacy had succession planning in place. This included enrolling a dispenser onto qualification training so they would be eligible to register as a pharmacy technician. It also included enrolling team members onto the relevant training courses so they would be accredited to carry out final accuracy checks. The pharmacy provided some protected learning time in the workplace so that team members completed mandatory training. This included keeping up to date with 'standard operating procedures' (SOPs) and completing pharmacovigilance training such as UK GDPR and safeguarding procedures. Team members completed other relevant training depending on service demands. This had recently included Malaria awareness training. The following team members worked at the pharmacy; one full-time pharmacist, one part-time pharmacist, two full-time dispensers, eight part-time dispensers, one full-time medicines counter assistant and two part-time medicines counter assistants.

The RP supported team members to learn and develop and keep up to date with changes and new initiatives. This included the use of a WhatsApp group which helped them to manage the risk of part-time team members missing important information due to shift patterns. A recent message had reminded them to check Owings to manage the risk of people going without their medication. The RP consulted with team members before they implemented changes. For example, they had been involved in the decision to rearrange the stock layout in the dispensary. This had helped team members with stock management procedures and made it easier for them to retrieve items. The RP also encouraged team members to make suggestions to improve the pharmacy's working arrangements. A recent suggestion had led to a review of serial prescription dispensing. This had led to improvements and had

made prescription retrieval more effective. Team members discussed near miss errors and dispensing mistakes to improve working practices to keep services safe.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

A sound-proofed consultation room with a sink was available for use. And it provided a clinical environment for the administration of vaccinations and other services. The consultation room also provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. A separate hatch was also available and provided extra privacy should people wish to use it. Team members cleaned and sanitised the pharmacy regularly, and this ensured it remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible for people. And it manages its services well, so they are provided safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had good physical access with car parking and a level entrance. It used an information leaflet which provided people with details of the services it offered and its contact details. Team members also kept a range of healthcare information leaflets for people to read or take away. The pharmacy team had knowledge of the Pregnancy Prevention Programme (PPP) 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 the specified area annotated on the tablet box to prevent 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.

The pharmacy had segregated areas for its activities, such as for labelling, dispensing, and the checking of prescriptions. Team members used dispensing boxes to safely store medicines and prescriptions throughout the dispensing process. This helped manage the risk of medicines becoming mixed-up. The pharmacy sent around half of the prescriptions it received to an offsite hub pharmacy for dispensing. And team members only sent those that met the company's inclusion criteria following an assessment. They processed prescriptions on the pharmacy's 'patient medication record' PMR system. And they annotated them and placed them in a box awaiting a clinical check. The pharmacist carried out accuracy and clinical checks on each prescription. But sometimes they completed the checks retrospectively after they had been sent to the hub pharmacy. This meant that team members did not always follow the company's procedures. And they did not always comply with the necessary safety measures to manage risks and keep services safe. The hub pharmacy's turnaround time for prescriptions was 48 hours after they received them. And on receipt, team members placed them on the pharmacy's prescription retrieval shelves ready for people to collect.

The pharmacy dispensed serial prescriptions as part of the Medicines: Care and Review service (MCR). Team members managed the dispensing of these prescriptions, so they were available for people to collect when they were needed. They monitored when people collected their prescriptions and highlighted non-compliance so that the pharmacist could intervene and discuss medication regimes with people. The pharmacy provided the NHS Pharmacy First service. And there was significant demand due to the pharmacy's extended opening hours. Team members were providing the service at the time of the inspection. And they were observed completing a Pharmacy First Referral form which they shared with the pharmacist to ensure they provided appropriate treatments and advice. The pharmacist provided a travel vaccination service via a range of private 'patient group directions' (PGDs).

The pharmacy stored pharmacy-only (P) medicines directly behind the pharmacy counter to prevent unauthorised access. And it obtained medicines from licensed wholesalers and stored these tidily on a series of shelves and in drawers. The pharmacy had a process for team members to follow to check the

expiry dates of the pharmacy's medicines. And they kept records to show that checks were up to date and when they had been completed. No out-of-date medicines were found following a check of 20 randomly selected medicines. The pharmacy attached short-dated stickers to packs to show those that were due to expire soon. The pharmacy had three medical grade fridges in use to store medicines that required cold storage. And the team kept records to show the fridges' minimum and maximum temperature ranges. A sample of the records showed the fridges were operating within the correct range of between two and eight degrees Celsius. The team annotated packs of liquid medicines to show the date when they were first opened to ensure they were discarded accorded to manufacturer's instructions. 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. This included a recent drug alert for Emerade injections. They returned items received damaged or faulty to manufacturers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders. They cleaned them after use and stored them appropriately to manage the risk of contamination. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.