General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 22-23 Block 6, Glasgow Fort Retail Park, GLASGOW, Lanarkshire, G34 9DL

Pharmacy reference: 1090040

Type of pharmacy: Community

Date of inspection: 11/09/2024

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they provide over-the-counter medicines and prescription-only medicines via patient group directions (PGDs).

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 has relevant written procedures for the services it provides. And team members follow these to help them provide services safely. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps accurate records as required by law, and it protects people's confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined its working practices in a range of relevant standard operating procedures (SOPs) and team members had access to them whenever they needed to refresh their knowledge. This included procedures for controlled drugs (CDs) and responsible pharmacist (RP) regulations. The superintendent pharmacist's (SIs) office regularly reviewed SOPs and team members read and signed them to confirm their understanding and ongoing compliance. The SIs office also developed and issued new SOPs following the introduction of new working practices. And team members read and signed them before the new working arrangements were introduced. This included new dispensing procedures that had been introduced in July 2024 for some of the pharmacy's prescriptions.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the pharmacists identify and help team members learn from their dispensing mistakes. The pharmacy had a framework in place to support patient safety. And one of the trainee pharmacy technicians was responsible for carrying out monthly reviews to identify and mitigate dispensing risks. This included an analysis of errors identified before they reached people, known as near miss errors. Team members kept records of their near miss errors to identify patterns and trends which they discussed at the end of the month. During the discussions, they agreed upon the necessary improvements to keep dispensing procedures safe and effective. The patient safety report for the previous month showed three areas of improvement that team members were focussing on. This included the immediate filing of prescriptions to manage the risk of hand-out errors. It also included the introduction of an extra accuracy check to manage the risk of labelling errors. Team members were aware of common look-alike, sound-alike (LASA) medications, such as amlodipine and amitriptyline and knew to take extra care when dispensing them. Team members knew to escalate dispensing errors, which were mistakes that were identified after a person had received their medicine. The pharmacist discussed the incidents with team members, so they learned how to manage risks to keep dispensing safe.

The pharmacy defined its complaints procedure in a documented SOP and team members knew to handle any concerns that people raised in a calm and sensitive manner. They sometimes spoke to people in the consultation room when necessary and they added relevant notes to people's medication records about their complaints when appropriate for future reference. Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed an RP notice which was visible from the waiting area and the RP record was up to date. A notice was also displayed to show when the RP was off duty. This helped to inform people that certain services were unavailable when the RP was absent.

Team members maintained controlled drug (CD) registers and they checked the balance recorded in the

register matched the physical stock, once a week. The pharmacy kept records of CDs that people returned for disposal which contained signatures to provide an audit trail when destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date.

The pharmacy trained its team members to safeguard sensitive information. This included managing the safe and secure disposal of confidential waste. The pharmacy defined its safeguarding of vulnerable people procedure in a documented SOP and team members knew when to escalate concerns and discuss them with the pharmacist to protect people. For example, when some people failed to collect their medication on time so that alternative arrangements could be arranged if necessary. A chaperone notice was on display in the waiting area, and advised people they could be accompanied whilst speaking with the pharmacists and team members in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The following team members were in post; two pharmacists, two full-time trainee pharmacy technicians, one full-time dispenser, one part-time dispenser, one part-time trainee dispenser, four medicines counter assistants (MCAs) and four part-time pharmacy students. Two store managers had completed qualification training, and this enabled them to provide dispensary cover as part of the pharmacy's business continuity arrangements. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one-time unless there were exceptional circumstances. Pharmacy students provided cover and relief dispensers were available when needed. The company's deployment team had arranged relief pharmacists to provide any necessary cover up until Christmas. They also arranged locum pharmacist cover at short notice when required. A detailed staffing rota was in place, and ensured there was adequate team members present to cover the pharmacy's extended opening hours.

The pharmacy provided protected learning time for team members undergoing qualification training. For example, the trainee pharmacy technicians were allocated a half day each week for training activities. The pharmacy had formal induction arrangements for new team members. This included the reading and signing of SOPs over an eight-week period to confirm adherence to the pharmacy's safe working practices. It also included health and safety training that they completed online. New team members had the opportunity to input into their training to suit their learning needs. For example, a new trainee dispenser had been authorised to use a quiet office to read the relevant SOPs and this had helped them to improve their concentration.

The pharmacy provided training before new services were introduced. One of the MCAs had completed training to give them the necessary knowledge and skills to support people selecting pharmacy only medicines (P-Meds) following a change to the pharmacy's layout. A trainee MCA made supervised supplies but knew to refer to the pharmacist when they needed extra help. Four team members had attended off-site training to gain the knowledge and skills to deliver the 'Our Nations Health' research study. This included taking blood samples using phlebotomy procedures and blood pressure and cholesterol readings. They learned about the rationale for having to follow the procedures. And they also had to demonstrate they were competent during training before they were accredited to provide the service. For example, they had to accurately take blood pressure measurements at least ten times under supervision. The training also included consultation skills and how to accurately submit the relevant information onto the data base for the study.

The pharmacy encouraged team members to provide feedback and suggest service improvements. They provided examples of recent changes, such as re-arranging the staffing rota so that an MCA provided cover in the evening to help manage the pharmacy's workload. This had helped reduce workload pressures. The pharmacy had a documented SOP that defined the process for raising

whistleblowing concerns and it trained team members, so they understood their obligations to do so. This ensured they knew when to refer concerns to the pharmacist or another team member. They were also empowered to use a dedicated phone line to discuss concerns if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has good facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was within a large retail store and team members managed the workspace well to ensure dispensing procedures were conducted safely and effectively. The premises had been refurbished in July 2024. This had increased the pharmacy's capacity to carry out existing tasks and to introduce new services and initiatives. The premises included an enclosed rear area with dispensing benches that were used for various tasks such as the dispensing of multi-compartment compliance packs. This ensured sufficient space for the prescriptions and the relevant documentation to carry out the necessary checks and keep dispensing safe. It also included a separate workstation for new dispensing procedures for some of the prescriptions it dispensed. Separate workstations at the front of the dispensary faced onto the waiting area so that team members could easily communicate with people about their medicines and respond to any queries. The medicines counter had been removed and had been replaced with two separate workstations to support the selection of P-Meds. The pharmacist had good visibility of the area and could intervene when necessary. Blinds were used to cover the P-Meds to indicate they were not available for sale when the RP was absent.

The pharmacy had a large well-equipped consultation room, which was professional in appearance. A clean, well-maintained sink in the dispensary was used for medicines preparation. And team members cleaned all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services. The pharmacy was working in partnership with the NHS to deliver a research study called 'Our Future Health'. Volunteers attended the pharmacy to provide information and samples relating to their health. A large purpose-built consultation area was located next to the P-Meds area. This was being used to see people who were participating in the study and a waiting area was located nearby. Signage and information about the study were displayed at the consultation area so that people knew where to go. Pharmacy team members had been trained to provide the service. They cleaned the area in between consultations and at the end of the day.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was in a large retail park and provided its services seven days a week from Monday to Sunday. It opened until 22.00 on weekdays, 19.00 on a Saturday and 18.00 on a Sunday. People accessed the premises via a level entrance which helped with mobility difficulties. The pharmacy had recently introduced a new initiative which meant that people were able to select P-Meds. A risk assessment had identified some medicines that were unsuitable for people to access this way. These were displayed but were kept behind a locked Perspex screen and team members were able to retrieve them after asking appropriate questions to make sure they were suitable for the people that requested them. Two computers helped to manage the sales of P-Meds.

The system provided prompts, so that team members made safe supplies. For example, it provided information about maximum quantities for specific medications such as pseudoephedrine which was restricted to one pack at a time. The computers in the main store were not capable of scanning P-Meds and sales assistants advised people to return to the pharmacy so they were provided with the necessary advice at the time of the sale. Team members had unique credentials to log on to the system and this produced an audit trail of transactions to show who had made individual sales.

Four trained team members provided the ‘Our Nation’s Health’ service only when the RP was on duty. They also knew the RP had to sign a documented checklist on a daily basis to confirm that all the relevant SOPs and service arrangements were in place and being followed before the service could commence. Team members obtained documented consent from people, and they ensured they informed them that they could opt out of the study or decline to provide information or samples at any time. They knew to attach bar codes and ‘Our Future Health’ labels to samples and to place them in a secure container for signed collection by a designated courier at the end of the day.

The pharmacy had introduced new dispensing arrangements for some of its prescriptions in July 2024 following its refurbishment. Prescriptions were assembled using a semi-automated process. The pharmacist carried out a clinical check on the prescriptions before team members entered the prescription details on the patient medication record (PMR). The data was accuracy checked by the pharmacist before it was transmitted for the medicines to be ordered. The medicines were delivered in sealed totes with a unique barcode. Team members used barcode technology to match the medicines to the correct prescription. Prescription labels were printed and attached to the medicines. The medicine stock and prescription were scanned again to ensure the correct medicine was put in the correct person’s bag. If there was an error at any point, the barcode technology would alert a team member and an accuracy check was then performed by the pharmacist. The pharmacist continued to accuracy check all the items to provide assurance that the procedure was working as it should. And once the pharmacy reached 2500 items, the pharmacist would cease to carry out these additional accuracy checks and the pharmacy would rely on the bar code technology.

The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. This included regular date-checking which was documented so that team members knew when checks were next due. Team members highlighted short-dated items to manage the risk of near miss errors. A random check of dispensary stock found no out-of-date medicines. The pharmacy used four fridges to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated which helped team members manage the risk of selection errors. The pharmacy used secure cabinets for some of its medicines and these were kept well-organised. Separate containers were used to quarantine items whilst they awaited destruction. The pharmacy received drug safety alerts and medicine recall notifications. Team members checked the notifications and maintained an audit trail to show they had conducted the necessary checks. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant safety information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. It also helped them prioritise prescriptions, for example, for people that wished to wait on their medication. Team members dispensed medicines in multi-compartment compliance packs over a four-week cycle for some people. Team members used supplementary pharmacy records to document the person's current medicines and administration times. This allowed them to carry out checks and identify any changes that they queried with the GP surgery. Team members kept a schedule to show when people's compliance packs were due for delivery. They retrieved the packs from the storage shelf, and these were checked against the schedule to ensure they were correct. Team members supplied patient information leaflets (PILs) with the first pack of the four-week schedule, and they provided descriptions on the packs of to help people identify their medicines. The pharmacy used a dispensing pump to dispense substance misuse medicines. Team members dispensed the medicines on a weekly basis, and they knew to obtain an accuracy check from the pharmacist at the time of dispensing.

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, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. 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 conduct conversations in private if needed, using portable telephone handsets. The pharmacy used a dispensing pump to measure substance misuse medicines. And team members calibrated the pump to confirm it was measuring accurately.

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.