General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 59 West Main Street, Harthill, SHOTTS, Lanarkshire, ML7 5PU

Pharmacy reference: 1091211

Type of pharmacy: Community

Date of inspection: 18/06/2024

Pharmacy context

This is busy community pharmacy in the village of Harthill, Shotts. Its main activity is dispensing NHS prescriptions. It provides some people with their medication in multi-compartment compliance packs to help them take their medicine correctly and it provides a range of NHS services including Pharmacy First. It has a delivery service, taking medicines to people in their homes.

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’s written procedures help team members manage risk and provide services safely. Team members record errors made during the dispensing process to learn from them and they make changes to help prevent the same mistake from happening again. They keep the records required by law and they keep people’s private information secure. Team members have the necessary training to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These were reviewed by the company's superintendent pharmacist (SI) team every two years. Team members accessed newly updated SOPs on an electronic platform where they completed quizzes to confirm their understanding of them. And team members were up to date with these.

The pharmacy recorded mistakes identified and resolved during the dispensing process known as near misses. The team member who made the error recorded the details about it. Details of the mistakes were completed electronically. Team members discussed the mistakes made to help identify trends and suggested changes to help prevent the same or a similar mistake from occurring again. For example, team members identified errors involving the incorrect quantity of a medicine being dispensed. And so, a second check of the quantity dispensed was completed by another team member before being passed to the pharmacist for the final accuracy check. A team member completed a monthly patient safety review which was briefed to the other team members. The pharmacy completed incident reports for errors that were identified after a person had received their medicine. These were recorded electronically and shared with the area manager and the head office team if necessary. The pharmacy had a complaints policy which was detailed in the pharmacy's practice leaflet. Team members aimed to resolve any complaints or concerns informally. For any complaints that were received via the company's customer services team, the pharmacy manager aimed to resolve the complaint or escalated it to the area manager. Team members sought feedback from people accessing the pharmacy's services in the form of surveys.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. Team members were aware of the tasks that could and could not take place in the absence of the responsible pharmacist (RP). The RP notice was prominently displayed in the retail area and reflect the details of the RP on duty. The RP record was completed correctly. The pharmacy had a paper-based register for recording the receipt and supply of its controlled drugs (CDs). The entries checked were in order. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. And they were stored separately to ensure they were not mixed with routine stock. The destruction of returned CDs was witnessed by two team members. The pharmacy kept certificates of conformity for unlicensed medicines and details of who the medicines was supplied to, provided an audit trail. It kept complete electronic records for its supply of private prescriptions and kept associated paper prescriptions.

The pharmacy had a company data processing notice in the retail area which informed people of how

their data was used. Team members received annual training regarding information governance and General Data Protection Regulation. The pharmacy separated confidential waste for collection and secure destruction. It displayed a chaperone policy, informing people of their right to have a chaperone present for consultations that took place in the consultation room. Team members received annual training for safeguarding of vulnerable adults and children. They knew to refer any concerns to the pharmacist in the first instance. All team members were part of the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and competent team members to help manage the workload. Those in training receive appropriate supervision. Team members complete ongoing training to help develop their skills and knowledge. They suitably respond to requests for advice and sales of medicines.

Inspector's evidence

The pharmacy employed a full-time pharmacist. At the time of the inspection a locum was the RP. They were supported by a trainee dispenser who was also the pharmacy manager, and three dispensers, one of whom was also in training. The pharmacy employed a trainee pharmacist, a trained dispenser and a trainee dispenser who were not present during the inspection. A delivery driver worked three days a week. Team members had either completed or were in the process of completing accredited qualification training for their roles. The full-time pharmacist acted as tutor for the trainees and had regular meetings with them. Team members in training completed their training out with business hours. All team members received regular ongoing training on an online platform with the most recent training including policies and procedures and a review of SOPs. They received a monthly newsletter from the company which provided information and learnings from other pharmacies in the company. And they shared other general learnings with each other. The pharmacist had read patient group directions (PGDs) to be able to provide the NHS Pharmacy First service.

Team members were observed to work well together and were managing the workload. They communicated well with each other, and they had informal conversations about tasks to be completed. Annual leave was planned in advance so that contingency arrangements could be made. Team members from other pharmacies in the company or part-time team members could increase their hours to support periods of absence. The pharmacist and pharmacy manager received bi-annual performance reviews. There was an open and honest culture and team members felt comfortable to raise concerns with the pharmacist or manager if necessary. The company had a whistleblowing policy for its team members.

Team members asked appropriate questions when selling medicines over the counter and referred to the pharmacist if necessary. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. Team members highlighted such requests to the pharmacist who had supportive conversations with people. And they were vigilant to monitor the frequency people requested their prescriptions and highlighted concerns to the person's GP. The pharmacy set its team members targets and team members did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy premises comprised of a spacious retail area and dispensary. There was a medicines counter which was kept tidy and portrayed a professional appearance. The medicines counter was situated directly in front of the dispensary and there was a barrier to prevent unauthorised access to the dispensary. The dispensary was small and team members managed the limited space well. There was an organised workflow and different benches were used for different tasks. There was a very small stock room adjacent to the dispensary which led to a room for team members to have their breaks. There was limited space to move around the stock room freely, but team members managed this as best they could. The pharmacist's checking bench was positioned in the dispensary so they could supervise the dispensary easily and intervene in conversations at the medicines counter if necessary. The dispensary had a sink which provided hot and cold water. And toilet facilities were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable. Team members kept the pharmacy clean.

The pharmacy had a lockable soundproofed room adjacent to the medicines counter which allowed people to have private conversations and access services. There was a computer, desk and chairs for consultations to be completed comfortably.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members complete regular checks on medicines to ensure they are fit for supply. They provide people accessing services with relevant information to help them take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had steps, a ramp and automatic doors to provide ease of access to those using wheelchairs or with prams. Team members helped people who did not speak English as their first language by using translation applications. The pharmacy had a range of healthcare leaflets for people to read or take away. And they signposted people to other service providers for services they did not offer. The pharmacy's services such as NHS Pharmacy First were underpinned by PGDs which were up to date and signed by the pharmacist. The pharmacy's dispensing processes used barcode technology to help with accuracy of medicine selection. Team members processed prescriptions on the patient medication record (PMR) which were checked for clinical appropriateness by the pharmacist. And the information was electronically transferred to the pharmacy's wholesalers after a data accuracy check was completed by the pharmacist. When the required medicines were received in the pharmacy, a dispenser used the barcode technology to accurately match the prescriptions and associated medicines labels with the correct medicines.

Team members used containers to keep people's prescriptions and medicines together and reduce the risk of errors. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Laminated cards were attached to prescriptions to highlight the inclusion of fridge lines, CDs or higher-risk medicines such as valproate. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They were aware of recently updated legislation for providing valproate in manufacturer's original containers. The pharmacy did not provide valproate to any people in the at-risk category. Team members were observed asking appropriate questions when handing out medicines to ensure they were provided to the correct person. They provided people with an owing slip, which was a record of the medicines they could not provide the full quantity of. Team members checked prescriptions with owed medication daily and if the item could not be supplied an alternative was sought from the person's GP.

The pharmacy supervised the administration of medicine for some people. Team members prepared the medicine in advance, so it was ready for people to collect. They had paper communication records for some of the people who accessed this service and planned to complete this for all people. This meant they had up to date contact details for these people and have a written record of communications about their treatment.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions in advance of them being required so that any queries could be resolved in a timely manner. Each person had a medication record sheet which detailed the medicines and administration times. Any changes to a person's medication were communicated to the pharmacy from the GP or via a hospital discharge

notification. People had written descriptions of the medicines in the packs so they could be easily identified. And team members supplied patient information leaflets once a month so people could read about the medicines they were taking. Team members added the details of medicines to be delivered to an online platform, this included highlighting the inclusion of a fridge line or CD. The driver used an electronic device as a record of the deliveries to be made. Any failed deliveries were returned to the pharmacy and a note was left informing people a delivery had been attempted.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on the dispensary shelves in alphabetical order. Pharmacy only (P) medicines were stored behind the medicines counter which ensured sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. And records showed these checks were last completed in May 2024. Medicines expiring in the next three months were highlighted for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. A random check of medicines found all in date and one short-dated medicine that had not been highlighted. This was highlighted to the pharmacy manager for resolution. The pharmacy had two fridges to store medicines that required cold storage. And records showed the fridges were operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls directly from the company on an online platform. They signed the records after action had been taken and retained for future reference. And the information was communicated to team members. The pharmacy kept medicines returned by people who no longer needed them in pharmaceutical waste containers for destruction by a third party.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people’s private information.

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had crown-stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had clean triangles used to count tablets and a separate clean capsule counter.

The pharmacy had cordless telephones so that conversations could be kept private. And it stored medicines awaiting collection in the dispensary so that people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned in a way that meant only authorised people could see the information on the screens.

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.