General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 2B East Road, IRVINE, Ayrshire, KA12 0AA

Pharmacy reference: 1094204

Type of pharmacy: Community

Date of inspection: 22/11/2022

Pharmacy context

This is a community pharmacy in a small branch of Boots. The Boots store is in a retail park on the outskirts of Irvine. The pharmacy provides a range of services including dispensing private and NHS prescriptions. And 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 flu vaccination 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 identifies and manages the risks associated with its services well. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has written procedures to help ensure that its team members work safely. And the team 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 appropriately.

Inspector's evidence

The responsible pharmacist (RP) explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. This was partly due to staff shortages. But it was also due to an increase in the number of prescriptions it dispensed. And so, for a while the pharmacy increased its hours of opening to manage the extra workload. But more recently, although the pharmacy was still very busy with prescriptions, the total number it dispensed had fallen again. And so, the pharmacy had reduced its opening hours to suit the adjusted workflow. It did this with the support of line managers and the local health board. And it had reduced its opening hours by one hour each day from Monday to Saturday when the pharmacy was quiet. And did not have many people coming in. By reducing its opening hours, the pharmacy found enough staff cover as it no longer needed to find team members to cover the hours between 6pm and 7pm each evening. When necessary, staff from other branches of Boots worked at the pharmacy and vice-versa. The pharmacy had reduced its range of services during the pandemic. It had done this in part because of a lack of demand. And to concentrate on delivering a safe dispensing service. But since restrictions had lifted it had been able to offer more of its other services. And it had expanded its range of patient group direction (PGD) based services. So, it could treat more conditions by supplying a greater range of prescription medicines through those PGDs.

The team had a system for recording its mistakes. It recorded them electronically and reviewed them monthly in its patient safety review meetings. The pharmacist was one of two regular RPs. She described how she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. This enabled them to reflect and learn. Records showed that the team had been encouraged to do their own accuracy check on what they had dispensed before transferring to the pharmacist or accuracy checking technician (ACT) for a final accuracy check. The team recognised the importance of monitoring and reviewing near misses and errors so that it could learn as much as possible from them. It agreed that records should reflect what the team member had learned and what could be done differently next time to prevent mistakes and promote continued improvement. 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 specific treatment or condition. The RP demonstrated how the team had separated stocks of ciprofloxacin and clarithromycin after reading in the newsletter that there was a risk of mistakes between the two. It had done the same with folic acid 5mg tablets and prochlorperazine 5mg tablets where the branded packaging made the two products look very alike.

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. They appeared to understand their roles and

responsibilities and were seen consulting the pharmacist when they needed her advice and expertise. The RP had placed her RP notice on display where it could be seen by people. The notice showed her name and registration number as required by law. People could give feedback on the quality of the pharmacy's services. Each till receipt had information on the back on how people could report their experience of how they had been treated at the pharmacy. People could also give feedback directly to team members. 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 customer feedback was usually positive. And the team usually dealt with any concerns at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

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. 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 kept records of emergency supplies. And the RP agreed that the records should give a clear explanation for the pharmacist's decision to supply.

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. Team members had completed appropriate safeguarding training. And they knew to report any concerns to one of the pharmacists. The team could access details for the relevant safeguarding authorities online. And it also had a poster on display with the relevant contact details. The pharmacy kept a record of any referrals it made.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy trains its team members for the tasks they carry out. It manages its workload safely and effectively. And its team members support one another. Team members are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. One of the two regular RPs was present along with an ACT, two dispensers, two pharmacy advisers (PAs). And a trainee PA. The PA role provided the team member with dispensing assistant training and medicines counter assistant training. The pharmacy had two part-time RPs who covered the pharmacy's opening hours between them. This helped to provide services without causing additional disruption to the dispensing service and the pharmacy's other services. And overall, team members were seen to work effectively with one another. The pharmacy had a team who worked regularly together. The daily workload of prescriptions was in hand.

Pharmacists could make day-to-day professional decisions in the interest of people and did not feel under pressure to meet business or professional targets. And team members could discuss their concerns with their line managers. They generally discussed issues as they worked. And they described how, during the pandemic, they got together to make suggestions about how they could improve the way they managed the workflow. They did this so that they could get more prescriptions ready for people when they came to collect them. This reduced the time that people had to wait. And it reduced the number of visits they had to make to the pharmacy. Staff described feeling supported in their work by their colleagues and their managers. They had regular reviews about their work performance. And 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 was in a small retail park. It occupied a single storey. And it had a clean, bright, modern appearance. It had a relatively spacious retail space with a consultation room and a waiting area. The pharmacy had a small counter unit with a till instead of a full medicines counter. But team members didn't use the unit very often. They preferred to serve people from the dispensary reception area, which also had a till. The pharmacy kept its pharmacy medicines in lockable cabinets next to the counter unit. And it had screens on top of the unit 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 regularly. And it kept the premises clean and tidy.

On one side, the dispensary had workbenches part-way around three walls with storage areas above and below. This was where the pharmacy team carried out most of its dispensing activities. When the pharmacy's dispensing activity was at its busiest, it did not have much free workspace. On the other side, it had a small workstation which faced the rear of the dispensary. The pharmacist used this workstation for checking prescriptions. The checking area had storage shelves next to it. And the pharmacy stored its completed prescriptions here. The checking area also had a small hatch from where the team could hand out prescriptions. This was separate to the main prescription reception area. And it provided an area for team members to have more discreet conversations with people about their medicines. The dispensary had shelves and pull-out drawers for storing medicines. And for storing prescriptions which were at various stages of the dispensing process. The pharmacy team stored its dispensed items and prescriptions so that people's information was kept out of view.

The pharmacy dispensed a relatively high number of prescriptions. And it had just enough space for its current activity. So, team members took care to dispense and store one prescription at a time. And they kept prescription baskets stacked tidily, clearing away stock medicines as they worked. And although the pharmacy had a back area which provided a small amount of additional dispensing space, it did not have enough space to offer a multi-compartment compliance pack service. And so, the service was only offered to people in exceptional circumstances. The back area had a small amount of additional storage. It also had a staff area and staff facilities. And it had a rear door which was used by its delivery drivers.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures help ensure that its services are supplied safely and effectively. 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 double automatic doors. And the team kept the retail area 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 could also order people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It did not generally provide medicines in multi-compartment compliance packs for people. This service was provided from other local branches, which had the space to manage the service.

The RP gave people advice on a range of matters. And she explained how she would give appropriate advice to anyone taking higher-risk medicines. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This included people in the at-risk group. The RP described how she counselled these people when supplying the medicine to ensure that they were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets 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 ibuprofen and paracetamol. And threadworm treatments for children. Team members knew when to refer 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 flucloxacillin for impetigo, emergency hormonal contraception and flu vaccinations.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The team knew how to process serial prescriptions. And it 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. The RP used the pharmacy care record to identify people for review. These were often people on regular repeat prescriptions. She used the NHS medicines care review (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 obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately. And stock on the shelves was 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 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 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.