General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 89 - 91 Main Street, PRESTWICK, Ayrshire, KA9 1JS

Pharmacy reference: 1095662

Type of pharmacy: Community

Date of inspection: 17/04/2023

Pharmacy context

This community pharmacy is on a high street in the town of Prestwick. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy provides medicines to several people in multi-compartment compliance packs to help them take their medication. And it supplies serial prescriptions as part of the NHS Medicines: Care and Review (MCR) service. The pharmacy offers other services such as NHS Pharmacy First Service and it delivers medicines to some people's 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	Good practice	2.5	Good practice	The pharmacy has regular meetings where team members are encouraged to share ideas on how to improve the delivery of services. And they actively engage in planning for changes that may affect their workload. Team members receive regular feedback on their performance and are encouraged to identify opportunities to further develop their knowledge and skills.
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. It completes the records it needs to by law and it suitably protects people's confidential information. Team members provide people with information on how to raise a concern and they manage concerns well. They have training and guidance to help them understand their role in protecting vulnerable people. Team members record and discuss any mistakes they make to ensure they learn from them. But they don't always capture key information in these records to help aid future learning.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). Team members accessed the SOPs via an online platform and answered a few questions to confirm they had read and understood them. They received notification of new SOPs or when changes were made to existing SOPs, and they had protected time at work to read them. Team members demonstrated a clear understanding of their roles and responsibilities and they explained what to do in the absence of a responsible pharmacist (RP).

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions, known as near miss errors. The team member involved was asked to identify their error and correct it. A record of the near misses was kept on a paper template to help ensure they were captured at the time they occurred. The information from the paper record was transferred to an electronic platform each month. Team members discussed their errors and why they might have happened. But in the records seen, they sometimes did not capture this information to help inform the analysis of near miss errors. The pharmacy completed electronic records of errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident and the actions taken to prevent a similar incident. The near miss errors and dispensing incidents were regularly reviewed by the trainee technician who shared the outcome from the review with all team members. And discussed with the team the changes that could be made to prevent future errors. Recent reviews identified a decrease in the number of near misses recorded which the manager linked to disturbances caused by the significant building work taking place in the pharmacy. This was discussed during team meetings and team members reminded to take their time when dispensing in such situations. Incorrect quantities of medicines were highlighted to the team as common near miss errors. The team was reminded to double check the quantity of medicine dispensed especially when it was from a split pack.

The pharmacy had a concerns and complaints procedure which was detailed in an information leaflet located in the retail area. Team members aimed to initially resolve a concern raised and if they could not, they escalated it to the manager or RP. Team members were observed handling a concern well and provided assurance to the person raising the concern. People using the pharmacy were given 'How did we do?' cards and asked to complete an online survey about the pharmacy's services. A recent completed survey had thanked the team for going above and beyond to ensure a person received their medication.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The

team completed regular balance checks of the CDs and the balance of a randomly selected CD register was checked and found to be correct. Records of CDs returned to the pharmacy for destruction were kept. There was a documented procedure to help team members manage people's private information. And they understood the importance of protecting people's confidentiality. Information was displayed for people to read about how the pharmacy protected their confidential data. Team members spoke quietly to people in the retail area to ensure confidentiality. And they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures, training and guidance for the team to follow. The pharmacist was registered with the Protecting Vulnerable Groups (PVG) scheme and had completed safeguarding training via NHS Education for Scotland (NES). Team members responded well when safeguarding concerns arose and they liaised with the local social services team when they identified a person needed support to take their medication.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work very well together, and they are good at supporting each other in their day-to-day work. They discuss ideas and identify ways to support the effective delivery of the pharmacy's services particularly at times of increased workload. Team members complete ongoing training to help them develop their knowledge and skills. They benefit from identifying areas of their own practice they wish to develop and are supported to acquire new skills.

Inspector's evidence

Two part-time pharmacists covered most of the pharmacy's opening hours and often worked together. Locum pharmacist support was used when required. The pharmacy team consisted of an accuracy checking technician (ACT) who was also the pharmacy manager, a part-time trainee technician, a full-time dispenser, a part-time dispenser, a full-time trainee dispenser and two part-time trainee dispensers. All team members except the two part-time trainee dispensers were present at the inspection. The pharmacy had recruited a full-time dispenser but they had not started in the role at the time of the inspection. Trainees were given protected time at work to complete their training and received support from experienced team members. And they received a formal review at key points during their induction and training.

The ACT pharmacy manager scheduled protected time to complete the accuracy checks of prescriptions to ensure they maintained their skills. And they helped colleagues with dispensing when required. The trainee technician had provided managerial support for the team when the pharmacy manager was on planned leave. And they had received support from other store managers and the team. A buddy system was in place to support colleagues working at the pharmacy counter. A team member was allocated to this role each day which enabled other team members to focus on their tasks without being called to help at the pharmacy counter.

Team members were observed working efficiently and were managing the workload. The team's workload had increased over recent months due to the planned closure of a nearby pharmacy. And the premises had undergone a refit to provide more workspace and increase the storage arrangements. Team members had worked effectively during this period to ensure there was no disruption to services for people using the pharmacy. To support this the manager had asked for, and received, additional staffing hours so team members could increase their working hours. And planned leave requests were managed so that only one team member was absent at a time. The team had also been supported by team members from other pharmacies.

Team members used company online training modules to keep their knowledge up to date and they had protected time to complete the training. The pharmacy received a monthly professional standards newsletter from the pharmacy's head office that provided information about new services and learning from dispensing errors. Team members signed the newsletters to show that they had read and understood them. They received feedback on their performance, and they had opportunities to discuss their development needs.

Team members regularly held meetings where they planned their workload and discussed any

professional concerns and findings from the near miss review. The discussions from the meetings were documented and shared on a notice board so team members not able to attend were aware. Team members were encouraged to give feedback and they had recently provided ideas about the new pharmacy layout such as the appropriate workspace for tasks such as dispensing prescriptions. The pharmacy manager was actively involved in the plans for the refit and reported post-refit issues to be fixed. The pharmacy had a whistleblowing policy and team members knew how to access this. Targets were set for some pharmacy services and team members were aware of them. However, they agreed to not focus on these at the time of increased workload and the pharmacy refit to ensure they provided a safe and effective service to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are bright, clean and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were bright and clean and presented a professional image. They had recently undergone a refit which created additional workspace and storage for the team to use. The pharmacy was hygienic with separate sinks for the preparation of medicines and hand washing. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter.

The pharmacy had enough storage space for stock, assembled medicines and medical devices. The team kept floor spaces clear to reduce the risk of trip hazards. There were a few damaged drawers in the dispensary which had been reported to the pharmacy's head office and were due to be repaired. And the pharmacy manager had requested an extension of the wall between the dispensary and pharmacy counter to provide a quiet area for the team to work in.

The window displays detailed the opening times and the services offered and there was a defined professional area. Items for sale in this area were healthcare related and there was a clear view of the pharmacy counter from the dispensary. This meant the pharmacist could hear conversations at the counter and could intervene when needed. Room temperatures were suitable for storing medicines and air conditioning was available when required.

There was a suitably equipped, soundproof consultation room that was kept secure when not in use. The team used this for private conversations with people and when providing services. There was a hatch in the consultation room to the dispensary where people received supervised doses of their medication in private. And this was closed when not in use to enable private consultations to take place. Due to the recent re-fit the team was temporarily storing some pharmacy stock in tote boxes in the consultation room. The boxes were stored in an organised manner and didn't create a trip hazard for people using the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible for people. And it manages its services well. Team members work collaboratively with other pharmacy teams and healthcare professionals to suitably plan for changes to the delivery of pharmacy services in the area. This helps ensure people receive safe and effective care. Team members obtain medicines from reputable sources and they carry out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door operated with a press pad. It had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team provided people with information on how to access other healthcare services and it kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to.

The NHS Pharmacy First and Pharmacy First Plus services were popular particularly for medical conditions such as urinary tract infections. And the team provided people with a range of medicines to treat minor ailments through the service. Team members asked appropriate questions when selling medicines over the counter and they monitored people's requests to buy over-the-counter (OTC) medicines to ensure the supplies were suitable. Any concerns regarding a person's request to buy an OTC medicine were referred to the pharmacist. Pharmacy only OTC medicines were kept in glass fronted cabinets in the retail area with public access. The cabinets were locked to prevent unauthorised access and there was a sign to alert people to not select the medicines themselves.

A nearby Boots pharmacy was closing the week of the inspection and had provided several people with services such as the MCR service and dispensing medicines into multi-compartment compliance packs. Both teams worked together to ensure people were aware of the closure and to make sure their healthcare needs were not affected by the change. This included plans to efficiently transfer the MCR prescriptions for people who consented to use the pharmacy without impacting on the supplies of their medication. The MCR prescriptions in use could not be moved from the pharmacy that was closing so they were marked as finished. And a treatment summary report (TSR) was sent to each person's GP practice who was also advised of the change of pharmacy. This triggered the person's prescriber to review their MCR prescription before a new set of serial MCR prescriptions were sent. The team received a copy of the person's MCR paper record so they knew when previous supplies had been made and could see the recent TSR. Team members set up a file for this information and they referred to it when checking each person's new set of serial prescriptions when they arrived. This ensured the new set of prescriptions were organised for the dates when supplies were due and there was no interruption to the person's treatment. The team advised local GP teams of the closure of the pharmacy and people's request to use this pharmacy so new prescriptions were provided in time for supplies to be made. This also reduced the risk of people receiving additional supplies of medication they didn't need and the team not acting on medication changes during the transfer.

The pharmacy provided multi-compartment compliance packs to help around 137 people take their medicines. The trainee pharmacy technician managed this service with support from other team members. Prescriptions were ordered several days before supply to allow time to deal with issues such

as missing items. Each person had a record listing their current medication and dose times which was regularly referred to during the dispensing and checking of the prescriptions. Completed packs were stored tidily in magazine-type box files labelled with the person's name and address. The team recorded the descriptions of the medication within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. With people's consent the team provided the service for people who had used the Boots pharmacy that was closing. The two teams worked closely to ensure an efficient transfer of people's prescriptions. And they had completed the process gradually to allow time to prepare the packs and generate the accompanying documentation.

The pharmacy supplied a few people's medicines daily as supervised and unsupervised doses. The doses were prepared in advance to reduce the workload pressure of dispensing at the time of supply. And these were stored securely with people's doses separated from each other to help ensure the correct person's dose was selected. The pharmacy provided a needle exchange service that included the safe disposal of bins containing used needles. People returning the bins placed them directly into an appropriate waste bag embedded in a sealed unit which meant the team didn't handle the bins.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Team members used baskets to keep people's medicines with the correct prescription. And they initialled the checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A quad stamp on the prescription captured who had downloaded the electronic prescription, who had completed the clinical and accuracy checks and who had handed out the medication. Information identified during the dispensing process, such as a new medicine or a dose change was written down and kept with the prescription. This meant the pharmacist was aware and it prompted the team to discuss the information with the person when handing over their medication. Team members used alert cards for higher-risk medicines to prompt the pharmacist to ask for information from the person such as their latest blood test results. So, they could assess whether the medicines were suitable to supply. Team members had received training on the criteria of the valproate Pregnancy Prevention Programme (PPP), and they knew the information to be provided for people when required. A regular review of people prescribed valproate was undertaken and helped to identify anyone who may meet the PPP criteria.

The pharmacy obtained medication from several reputable sources and the team members followed the pharmacy's procedures to ensure medicines were safe to supply. They checked the expiry dates on stock and kept a record of this. Team members were developing a new matrix to reflect the changes to storage arrangements since the refit. Medicines with a short expiry date were marked to prompt the team members to check the medicine was still in date. And they kept a list of medicines due to expire each month. No out-of-date medicines were found. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And it stored out-of-date and patient returned CDs separate from in-date stock in CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Team members printed off the alert, actioned it and kept a record.

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 reference sources and access to the internet to provide the team with up-to-date and clinical information. The pharmacy had equipment available for the services provided which included a range of CE marked equipment to accurately measure liquid medication and a set of clean tablet counters. There was a separate marked counter for higher-risk medicines to avoid any cross contamination. And a fridge with glass door that enabled the team to view the stock held without prolong opening of the door. The pharmacy completed safety checks on the electrical equipment.

The pharmacy computers were password protected and positioned in a way to prevent disclosure of confidential information. Team members used cordless telephones to help ensure their conversations with people were held in private. The pharmacy stored assembled medicines in drawers and shelving along the dispensary wall which prevented personal information on bag labels and prescriptions being visible from the public 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.