

Registered pharmacy inspection report

Pharmacy Name: Boots, 34-41 Thistle Shopping Centre, Stirling,
Stirlingshire, FK8 2EE

Pharmacy reference: 9010963

Type of pharmacy: Community

Date of inspection: 18/10/2023

Pharmacy context

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

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 team members work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing and they keep records to identify patterns in the mistakes. And then take the opportunity to improve and reduce the risk of further errors. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. Team members understand their roles in protecting vulnerable people. And they complete regular training to ensure they are up to date with safeguarding requirements.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working arrangements. The company regularly issued new and updated digital SOPs and they were available for team members to view via an application (App). The SOPs were also available on the pharmacy computers and the procedure for core dispensing tasks was seen to valid until 1 May 2025. The company also issued hard copies of the SOPs. And these were available to view in a folder in the downstairs dispensary. But the procedure for core dispensing tasks had expired on 1 May 2023 and it had not been replaced. Team members read the new SOPs online, and they answered relevant questions to test their understanding. The pharmacy displayed the responsible pharmacist (RP) notice. And it showed the name and registration number of the pharmacist in charge.

Pharmacy team members signed dispensing labels to show they had completed a dispensing task. This provided an audit trail and helped the RP and the accuracy checking pharmacy technicians (ACPTs) to provide dispensers with feedback about their errors. The RP discussed errors in the main dispensary, and a second pharmacist and an ACPT spoke to dispensers in the downstairs dispensary that was used for care home services and other dispensing. Team members documented their near miss errors once they had corrected and reflected on them. Patient safety leads in each of the dispensaries carried out a monthly near miss review. And they discussed any patterns and trends with their colleagues so they could learn about new and emerging risks. This helped them to identify improvement actions to keep services safe. There was evidence of ongoing improvements in each of the dispensaries. This included taking more care when dispensing weekly prescriptions so that dispensing was carried out in an accurate, timely manner. It also included taking more care to manage the risk of quantity errors. The company issued a list of look alike and sound-alike (LASA) medication to highlight dispensing risks. And team members kept the list beside the patient medication record (PMR) for ease of access. Team members annotated prescriptions to highlight LASA medication and to highlight the dispensing risks to each other. Team members were also proactive at managing risks and they had highlighted an increased number of spelling mistakes on prescriptions so it could be discussed at a higher level. Team members also knew to document interventions on an electronic pharmacist information form (PIF) for the pharmacist to review.

Team members knew how to manage complaints. And the pharmacy used a practice leaflet to inform people about the complaints process. Team members knew how to report dispensing mistakes that people reported after they left the pharmacy. And they recorded and submitted the reports online to their area manager and superintendent pharmacist's office in the event they needed to take further action. An area manager visited the pharmacy on a regular basis, and they conducted audits to confirm that team members were complying with professional standards. They had recently discussed record

keeping and team members had agreed to take action and make improvements.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the RP record up to date. The pharmacy had public liability and professional indemnity insurance in place, and it was valid until 30 June 2024. The pharmacy team kept the controlled drug (CD) registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample trimethoprim PGD was valid until August 2024.

Team members filed prescriptions so they could easily retrieve them if needed. They completed regular mandatory training, and they knew 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. Team members completed regular training and knew how to manage safeguarding concerns effectively. The pharmacy maintained a list of useful contact numbers so that team members could contact people in a timely manner.

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 throughout the week. Team members have the right qualifications and skills for their roles and the services they provide. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they discuss mistakes to learn from each and improve their performance.

Inspector's evidence

The pharmacy's prescription workload had increased since the closure of a nearby supermarket and service changes in another supermarket pharmacy that was close by. At the time of the inspection there were long queues of people to be seen. And team members appeared to be managing it well with a turnaround time of 20 minutes mostly met. There had been recent staffing changes with the regular ACPT leaving to take up another role. And the pharmacy had been unable to recruit a replacement to carry out final accuracy checks for care home and multi-compartment compliance pack prescriptions. Two relief ACPTs had been providing cover for most of the week as an interim measure. The regular RP had been in post for around one year and double pharmacist cover was provided around three days per week. This was mostly to conduct clinical checks and authorise ACPTs to conduct final accuracy checks for care home and multi-compartment compliance pack prescriptions. The ACPT on duty demonstrated the accuracy checking procedure she followed and knew only to check prescriptions that had been annotated and signed by a pharmacist.

The RP had completed the necessary training to deliver the private flu vaccination service. But they had capped the service due to staff availability and the service was provided once a week when the pharmacy had double pharmacist cover. From time to time team members had to increase the prescription turnaround time to manage workload pressures and to manage people's expectations. This was mostly due to the RP having to check prescriptions for the care homes when there was no second pharmacist on duty. The pharmacy closed between 13.00 and 14.00 to ensure all team members received an adequate break.

New team members had been recruited in the past year to replace people that had left. This included three new full-time trainee dispensers. They had completed the company's formal induction process which included the reading of relevant SOPs and completing eLearning. They usually started working on the medicines counter and shadowed a nominated team member until they were deemed competent. The pharmacy provided some protected learning time in the workplace, but trainees mostly completed their learning in their own time.

Two separate pharmacy teams were in place. One team covered the main dispensary and the other covered the downstairs dispensary. Up until recently the teams had remained fixed, but there had been recent changes so there was more flexibility to provide cover across the teams. The pharmacy managed annual leave requests with only two team members permitted to take time off at the one time. The RP contacted the store manager to discuss staffing pressures and they mostly were able to arrange cover.

The following pharmacy support staff worked in the main dispensary; one full-time dispenser, one full-

time relief dispenser, two full-time trainee dispensers, one part-time dispenser, two pharmacy students and a medical student. The following staff worked in the downstairs dispensary; four full-time dispensers, one full-time trainee dispenser, one part-time dispenser and one full-time trainee dispenser.

The RP supported team members to develop in their roles. For example, they had responded to an article in the company's professional standards newsletter and had discussed the recent changes for dispensing sodium valproate medication in original containers. One of the dispensers confirmed they knew about the change and had implemented the new procedure. They also supported the pharmacy team with ongoing learning. This had recently included training about providing supplies of naloxone injections.

Pharmacy team members attended a monthly patient safety review meeting. This included a discussion about near miss errors and identifying at least three actions for the following month to keep services safe. They had discussed the bar-code scanning technology which checked and verified that the correct pack had been selected for dispensing. And they agreed to obtain an accuracy check from a colleague when packs did not contain a bar code. They also produced a PIF to inform the RP and the ACPT so they could apply extra accuracy checks. Team members were empowered to make suggestions for improvement. And the RP had recently highlighted excess stock due to ordering problems. They had asked for overtime so that team members could remove and isolate the extra stock. Team members understood their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises is secure, clean and hygienic. It has consultation facilities that are professional in appearance and they provide an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

The premises provided a modern, purpose-built environment over two floors from which to safely provide services. Team members labelled and assembled walk-in and surgery prescriptions in the main dispensary. And they used a large downstairs dispensary for care home and multi-compartment compliance pack prescriptions. The rooms were kept locked when necessary to restrict entry to authorised staff. A sound-proofed consultation room and a separate private hatch were next to the main dispensary and available for use. They provided a confidential authorised environment for people to speak freely with the pharmacist and other team members during private consultations. Team members regularly cleaned and sanitised 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 from which to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services in accordance with safe working practices. 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 show the pharmacy has arrangements in place to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy was in a large shopping mall and a step-free entrance provided access to the pharmacy which helped people with mobility difficulties. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to ensure that medicines were fit for purpose. This included the checking of dates, so they identified and removed items before they expired. Team members applied supplementary labels to packs to highlight short-dated stock and sampling showed that stock was well within its expiry date. The pharmacy used fridges to keep medicines at the manufacturers' recommended temperature. And team members kept an audit trail to show the fridges had remained with the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated. This helped team members manage the risk of selection errors. Team members used secure CD cabinets for some of its items and medicines were well-organised. And they kept items awaiting destruction well-segregated from other stock. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy used dispensing boxes to assemble medicines. This helped team members to keep medicines and prescriptions together during the dispensing process and manage the risk of items becoming mixed-up.

Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. And they knew to provide supplies in the original container due to recent legislative changes. This ensured the necessary warning labels were supplied with the packs. They also knew to apply dispensing labels so people were able to read the relevant information. The pharmacy received notifications of drug alerts and recalls which they prioritised. And they could show they checked for affected stock. For example, they produced a drug alert for Theramex which they had actioned in September 2023.

The pharmacy supplied medicines in multi-compartment compliance packs to people to help them with their medication. Team members used a large downstairs dispensary to assemble and store the packs to keep dispensing organised and safe. Supplementary records helped team members plan and dispense the packs to ensure people received their medication at the right time. And they referred to records that provided a list of people's current medication and the time of the day it was due. They checked new prescriptions for accuracy and kept records up to date following changes. The pharmacist carried out clinical checks and annotated prescriptions for the ACPT to refer to and conduct final accuracy checks. Some people arranged collection of their packs either by themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them identify when they needed to contact the relevant authorities to raise concerns.

The pharmacy supplied medicines to a significant number of care homes. The care homes mostly sent prescriptions for dispensing on time and the pharmacy had a dispensing schedule. This helped team members to manage the dispensing workload. Team members used a large downstairs dispensary to assemble medicines and organise them into totes for delivery. The pharmacy dispensed serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The pharmacy had a system for managing the dispensing of the prescriptions. And they retrieved prescriptions in advance so they could order items and dispense them in suitable time. Most people collected their medication on time. And team members knew to inform the pharmacist when people did not collect when they expected them to.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide safe services. And it has the necessary arrangements in place to restrict access to confidential 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 methadone. 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.

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.