

# Registered pharmacy inspection report

**Pharmacy Name:** Boots, 113 Wellhall Road, Hamilton, South Lanarkshire, ML3 9XN

**Pharmacy reference:** 9011073

**Type of pharmacy:** Community

**Date of inspection:** 14/03/2022

## Pharmacy context

This is a community pharmacy on a major route through Hamilton, Lanarkshire. It is situated in a residential area, close to a local medical centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including emergency hormonal contraception, smoking cessation, and supplies for people receiving care through substance misuse services. People obtain medicines for minor ailments through the pharmacy first scheme. Some people have their medicines delivered by the pharmacy. The pharmacy was inspected during the COVID-19 pandemic.

## 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
<b>1. Governance</b>	Good practice	1.1	Good practice	The pharmacy has some good systems in place to identify and manage risk. It checks the team's understanding of the written procedures to help make sure they provide services safely and effectively. When team members make a mistake, they identify learning to reduce the risk of it happening again and they share the learning with the rest of the pharmacy team.
		1.2	Good practice	Members of the pharmacy team are good at recording things that go wrong. And they routinely review the records to identify any learning. The records show the appropriate action taken, and how these actions help to improve the safety and quality of the pharmacy's services.
<b>2. Staff</b>	Standards met	2.2	Good practice	Members of the pharmacy team are appropriately trained for their roles. And they fully support newer members of the team whilst they undergo training. All members of the pharmacy team complete regular ongoing training to help them keep their knowledge up to date. And they receive protected time to learn while they are at work.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Good practice	4.2	Good practice	The pharmacy has good systems in place to counsel people who take high-risk medicines. And the team is good at monitoring people's compliance. This helps to ensure people are taking their medicines safely.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Good practice

### Summary findings

The pharmacy has written procedures in place to help ensure pharmacy services are safe and effective. It checks team members' understanding of these procedures and how well they follow them. The pharmacy keeps the records it needs to by law. And members of the team complete regular training so that they know how to keep private information safe. They record things that go wrong and are good at reviewing the records to help identify learning and reduce the chances of similar mistakes happening again.

### Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were routinely reviewed by the head office. Members of the pharmacy team had signed to say they had read and accepted the SOPs. Some SOPs had been recently updated and released electronically. There was an electronic dashboard for the pharmacist manager to track whether team members had read the SOP. After reading an SOP, each member of the team was required to complete a quiz to check their understanding.

A daily checklist was completed to check compliance for several professional requirements, including fridge temperature records, expiry date checks, weekly controlled drug (CD) balance checks, and display of the responsible pharmacist (RP) notice. An internal compliance audit was conducted by the store manager every quarter to check compliance with the company's procedures. On the last occasion the pharmacy had passed the audit with no major failings.

Near miss incidents were recorded on an electronic recording software. This produced analytical results of any common trends and were considered as part of a monthly review. The pharmacy technician gave examples of action which had been taken to help prevent similar mistakes. Such as writing the quantity onto the box to show the quantity had been checked during dispensing. Dispensing errors were electronically recorded and investigated. A recent example involved a fridge medicine which had been labelled correctly but supplied to a different patient. The pharmacy had identified learning to help prevent a similar mistake and team members now cross-checked labelled fridge medicines to ensure they belonged to the correct prescription. The company circulated a professional standard bulletin to share learning between pharmacies. Amongst other topics they covered common errors and professional matters. Members of the pharmacy team were required to sign the bulletin to confirm they had read it.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Team members wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. Any complaints were recorded to be followed up by the pharmacist manager or head office. Recent complaints had generally been about car parking outside of the pharmacy which had been referred to the head office. A current certificate of professional indemnity insurance had been seen.

Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. Patient returned CDs were

recorded in a separate register. Records for the RP, private prescriptions, and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team completed annual IG training and had confidentiality agreements in their contracts. When questioned, a dispenser was able to explain how confidential waste was segregated to be removed and destroyed. A sign in the retail area provided information about how people's personal data was handled.

Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. The pharmacist said she had completed safeguarding training. Contact details for the local safeguarding board were on display within the dispensary. A dispenser said she would initially report any concerns to the pharmacist on duty.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to manage the workload and they are appropriately trained for their roles. They fully support newer members of the team whilst they undergo training. All members of the pharmacy team complete regular ongoing training to help them keep their knowledge up to date. And they receive protected time to learn while they are at work.

### Inspector's evidence

The pharmacy team included three pharmacists, two of whom were pharmacist managers and shared the role, two pharmacy technicians, one of whom was trained to accuracy check, and seven dispensers, two of whom were in training. All members of the pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was two pharmacists, a pharmacy technician trained to accuracy check and six support staff. The volume of work appeared to be well managed. Staffing levels were maintained by part-time team members and a staggered holiday system.

The pharmacy provided the team with a structured e-learning training programme. And the training topics appeared relevant to the services provided and those completing the e-learning. The pharmacy provided team members with protected learning time to complete training. Electronic records were kept showing what training had been completed.

When questioned, the trainee dispenser explained she was currently completing her training to sell over-the-counter medicines. During this time, she said she would refer people to other members of the team and observe how medicines were sold. A dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed. The pharmacist said she felt able to exercise her professional judgement and this was respected by the other pharmacists she worked alongside, and the rest of the pharmacy team.

The dispenser felt she received a good level of support from the pharmacist and felt able to ask for further help if she needed it. The team was seen working well together and communicating important messages to one another. Appraisals were conducted by a pharmacist manager. A dispenser explained how the manager discussed her performance and said she felt able to speak about any of her own concerns. The team held weekly huddles about issues that had arisen, including when there were errors or complaints. Team members were aware of the whistleblowing policy and reported being comfortable raising any concerns to the manager or SI. A poster was displayed in the dispensary which encouraged team members to raise concerns. The pharmacy had targets for services such as pharmacy first and the pharmacist said she did not feel under pressure to achieve these.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided and the pharmacy acts to help make the premises are COVID secure. It has a consultation room available so people can have private conversations about their health.

### Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by use of a gate. The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette area and WC facilities.

Perspex screens had been installed at the medicines counter to help prevent the spread of infection. Markings were used on the floor to help encourage social distancing. Staff and customers were wearing masks. Hand sanitiser was available.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

## Principle 4 - Services ✓ Good practice

### Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. Members of the pharmacy team are good at checking people are taking their medicines properly. And they act appropriately to refer people to other healthcare professionals when needed. Team members carry out additional checks when they supply higher-risk medicines to ensure people are using them appropriately. The pharmacy gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

### Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. A service panel and pharmacy practice leaflets gave information about the services offered and information was also available on the website. Pharmacy team members were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed and leaflets provided information about various healthcare topics.

People from some of the local GP surgeries, could order their prescriptions through the pharmacy. For these people, members of the pharmacy team would ask which items they would like the pharmacy to order from the repeat prescription slip. A record was kept showing what items were requested.

The pharmacy had a delivery service for a few people. Deliveries were logged onto an electronic delivery system which provided an audit trail. Any unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The pharmacy team picked the stock against the prescription. They scanned each individual medicine for a label to be printed by the patient medication record (PMR). If the item was incorrect, the computer flagged this to the member of the team. A quadrant stamp was used and initialled to provide an audit trail showing who was responsible for each stage of the dispensing process, including dispensing, clinical check, accuracy check and handout. Any information which the team thought the pharmacist may need when checking the prescription was printed from the PMR and kept with the prescription until handout. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

If a prescription indicated it was to be dispensed in instalments at a set interval, an instalment docket or an official form was used to record the date of supply. The latest docket, or a copy of the docket, was kept after the final supply was completed in order to retain the last date of supply to show how compliant the person was. Members of the team said they would check compliance and question if a person was too early or late with picking up the prescription. Examples provided included a person where the GP surgery had authorised an early collection of a prescription earlier that day. And a referral to the GP surgery was made for a person who had not collected their medicine for a number of weeks. As the person had missed several doses of a particularly high dosage, the pharmacist was unsatisfied it

was safe to supply the medication without the person being reviewed by the GP.

Dispensed medicines awaiting collection were kept on a shelf using an electronic system to record the location. Prescription forms were retained, and laminates were used to clearly identify when fridge or CD safe storage items needed to be added. Team members were seen to confirm the patient's name and address when medicines were handed out. As an additional check, the person was asked to check the details on the bag label. Schedule 3 and 4 CDs were highlighted so that team members could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were also highlighted, and people were counselled about their medicines. Fridge and CD items awaiting collection were stored in clear bags so that the person and the pharmacist could confirm the accuracy of the dispensed item as an additional checking step. The team members were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. Dispensed medicines awaiting collection were highlighted to team members for counselling. The pharmacy technician said she would counsel the person when handing out the medication and refer to the pharmacist if the person met the risk criteria. But team members were unaware of any affected people.

An unscheduled care scheme enabled people to access medicines from the pharmacy at the pharmacist's discretion if they had been prescribed them before. The pharmacist said she had signed the relevant PGD in order to make the supply. An example from earlier that day involved a person who had ran out of their duloxetine medication. The pharmacist was able to supply 7 days' worth of medication, in the knowledge that the person had ordered their medication from the GP surgery.

The pharmacy first scheme was provided by the pharmacy. Members of the pharmacy team showed a good understanding of the service and the formulary of medicines which could be supplied. They provided examples of when they had made a supply on the scheme, and also when they had referred people elsewhere. Members of the pharmacy team would show the pharmacist the medicine to be supplied with an explanation of the reason. If the request was for a prescription only medicine permitted by the scheme, they would refer the person to the pharmacist for a consultation under the relevant PGD. A recent example provided by the pharmacist involved a person who was not within the inclusion criteria of the urinary tract infection PGD due to her age. And she was referred to the GP surgery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked on a 3-month basis. A date checking matrix was signed by team members as a record of what had been checked, and shelving was cleaned as part of the process. Short-dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out-of-date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had remained in the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the head office. Alerts were printed, action taken was written on, initialled and signed before being filed in a folder.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

### Inspector's evidence

The team had access to the internet for general information. This included access to the BNF and BNFC resources. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had last been PAT tested in December 2021.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

### 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.