General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 3 Pendre, CARDIGAN, Dyfed, SA43 1JL

Pharmacy reference: 1043228

Type of pharmacy: Community

Date of inspection: 13/08/2019

Pharmacy context

This is a high street pharmacy in a town that is a popular summer tourist destination. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including smoking cessation, treatment for minor ailments and a seasonal flu vaccination service for NHS and private patients. Substance misuse services are also available.

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	1.2	Good practice	Information about risk is reviewed and analysed to optimise the safety and quality of pharmacy services
2. Staff	Standards met	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their role and are supported to address their learning and development needs.
		2.4	Good practice	A culture of continuous improvement through learning exists within the team
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
		4.2	Good practice	The pharmacy has robust systems in place to support people taking higher-risk medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review their mistakes so they can learn from them. And they take action to help stop the same sorts of mistakes from happening again. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording and monthly analysis of dispensing errors and near misses. Monthly patient safety reviews documented that the pharmacy had been behind schedule for the past few weeks which the pharmacist felt had contributed to near misses. A staff member said that this was due to shortages of trained staff and an increasing number of walk-in prescriptions and queries from holidaymakers as the summer season had reached its peak. She explained that it was sometimes difficult to carry out meaningful root cause analyses on near misses as prescription items were often checked two or three days after they had been dispensed. However, she said that selection errors had reduced dramatically since the introduction of the new Columbus pharmacy software programme, which allowed many prescription items to be scanned so that the drug field in the patient medication record could be populated directly from the barcode. She said that most near misses tended to be quantity errors and staff had begun to routinely mark split boxes on all sides to avoid them being mistaken for an original pack. A trainee dispensing assistant was being taught to use a systematic checking technique when dispensing to help reduce the incidence of near misses.

Patient safety incidents throughout the company were collated and analysed and the learning points from the results were disseminated to the branches via a monthly superintendent newsletter. All staff had read and signed the most recent newsletter that was displayed on the dispensary noticeboard. Staff demonstrated that they used caution stickers to reduce the risk of incorrect selection for 'Look-alike, Sound-alike' or 'LASA' drugs and also marked prescriptions to further alert staff to the risk of errors with these drugs. A list of 'LASA' drugs was displayed at the labelling terminal and in the checking area. The risks associated with the influenza vaccination service had been assessed and posters describing the process to follow in the event of needlestick injury, fainting, anaphylaxis and seizures were displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided; these were regularly reviewed. The accuracy checking technician (ACT) said that she was able to perform any accuracy check on any prescription items that had been marked as clinically checked by the pharmacist, but in practice only checked items in compliance aid trays. Staff understood the activities that could and could not take place in the absence of the responsible pharmacist.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed in the consultation room showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, emergency supply records were not always made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors as some did not include the nature of the emergency. CD running balances were typically checked weekly.

Staff received annual training on the information governance policy and had signed confidentiality agreements as part of this training. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy computer that the system prompted them to change at regular intervals.

The pharmacist and staff had undertaken formal safeguarding training and had access to guidance and local contact details that were available in the dispensary. All staff were trained Dementia Friends. They were able to identify different types of safeguarding concerns and said that they would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was displayed in the retail area. Details of a local mental health support group were available in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist oversaw most professional activities. Relief pharmacists covered her absences on one day each week. She was assisted in the day-to-day operation of the pharmacy by the store manager, a trainee dispensing assistant. The pharmacy was busy at the time of the inspection but the atmosphere was pleasant and professional. There were enough suitably qualified and skilled staff present to safely manage the workload. The pharmacist said that there were enough staff to provide services safely but that they often had to break off from dispensing tasks to man the medicines counter. There was a risk that this distraction might have an adverse effect on the efficient operation of the pharmacy.

Staff members had the necessary training and qualifications for their roles; a trainee dispensing assistant worked under the supervision of the pharmacist and other trained staff. Two staff members were employed to work only in the non-pharmacy area of the shop and had not received any pharmacy training. The pharmacist said they did not cover the medicines counter and referred any requests for advice or medicines to pharmacy staff. The store manager said that the company were currently recruiting for another member of shop staff to help with the workload.

Targets were set for MURs but these were managed appropriately and the pharmacist said that they did not affect her professional judgement or patient care. Staff worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or Area Manager. A whistleblowing policy advertising a confidential helpline for reporting concerns outside the organisation was displayed in the dispensary.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services, completing regular paper-based self-assessments to reinforce this training. They were currently completing an assessment that tested their knowledge of the core dispensing SOPs. Staff also had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. The ACT understood the revalidation process. She said that she based her continuing professional development entries on situations she came across in her day-to-day working environment. All staff were subject to annual performance and development reviews and could discuss issues informally with the pharmacist or store manager whenever the need arose. The ACT received an interim review every six months.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The dispensary was generally clean, tidy and well-organised. It was small, but there was enough space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. The staff area on the first floor was not very tidy. Staff said they were aware of this but were currently prioritising the pharmacy service and would tidy the area later in the week when the store was quieter. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. If it can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. It supports people taking higher-risk medicines by making extra checks and providing counselling where necessary. And it generally manages medicines well.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as local sexual health clinics. Details of the local minor injury unit were displayed in the dispensary and details of a local podiatry clinic were available in the consultation room. Some health promotional material was on display in the retail area. The pharmacy was located in a Welsh-speaking area. The pharmacist and other staff members were fluent Welsh-speakers and many transactions were observed to take place in Welsh. The pharmacist had made visits to local surgeries to discuss and promote services as part of a health board-funded collaborative working initiative. A recent visit had involved discussions around the common ailments service.

Dispensing staff used baskets to ensure that medicines did not get mixed up during dispensing. Walk-in prescriptions were marked with laminated cards to identify whether the person presenting them was waiting or calling back. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. The endorsing machine or a quad stamp marked each prescription with a four-way grid that was initialled by all members of staff who had been involved in the dispensing process. Controlled drugs and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine.

Patient information forms were added to prescriptions to highlight issues such as a patient's eligibility for an MUR, or to make notes to convey information to the pharmacist. Stickers were used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. Coloured cards were used to flag up prescriptions for high-risk drugs such as warfarin, lithium and methotrexate: they included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information from the recipient, which was then recorded on the patient medication record (PMR). Cards were also attached to prescriptions to highlight the fact that a CD requiring safe custody or fridge line needed to be added before the prescription was handed out.

The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient prescribed valproate who met the risk criteria had been counselled appropriately and provided with information, She demonstrated that a record had been made on the PMR. A poster listing actions to be taken by the pharmacist when dispensing a valproate prescription was displayed and a folder containing valproate patient information was available in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

A text message service was available to let patients know their medicines were ready for collection. Prescriptions awaiting collection were marked with coloured stickers that corresponded to specific weeks of the month. They remained on the shelf for four weeks before the patient was contacted and the medicines returned to stock after another week if not collected.

The delivery service was managed electronically: patients or their representatives signed a handheld electronic device to acknowledge receipt of delivery as an audit trail. Separate signatures on paper forms were obtained for deliveries of controlled drugs. The pharmacist said that patients due to receive a delivery were telephoned beforehand to ensure that they would be at home. However, in the event of a missed delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy

Disposable compliance aid trays were used to supply medicines to a number of patients. The system was managed well and medicines were assembled in a designated area on the first floor. Trays were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. Each patient had a section in one of four dedicated files that included their personal and medication details, collection or delivery arrangements, details of any messages or queries and any relevant documentation, such as current prescriptions. A list of patients and a chart showing the progress of each person's compliance aid tray was available for reference at the front of each file.

Medicines were obtained from licensed wholesalers and stored appropriately, including those requiring cold storage. CDs were stored appropriately in a well-organised CD cabinet. Obsolete CDs were segregated from usable stock.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste. However, the pharmacist said that they were in the process of ordering one from their waste contractor and would segregate any cytotoxic waste they received in the meantime.

The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how the team had recently dealt with a drug recall for packs of prednisolone not marked with Braille by segregating these and ensuring that they were not supplied to patients with poor vision. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. It makes sure these are always safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. Triangles and a capsule counter were used to count tablets and capsules. They were a little dusty, but the ACT said they would be washed before use. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the computer was password-protected and the consultation room was used for private consultations and counselling. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

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.