General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 1-3 Vaughan Street, LLANELLI, Dyfed, SA15 3US

Pharmacy reference: 1043289

Type of pharmacy: Community

Date of inspection: 11/06/2019

Pharmacy context

This is a town centre pharmacy that sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It also provides dispensing services to a large number of care homes.The pharmacy provides a wide range of services including emergency hormonal contraception, treatment for minor ailments, pneumonia vaccination services 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	N/A	N/A	N/A
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
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 has written procedures to help make sure the team works safely. But its team members do not always record their mistakes. So it is likely that some chances to learn from them might be missed. 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 can 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 analysis of dispensing errors and near misses. Separate near miss logs were used for the main dispensary, a community MDS room and the care home dispensary. Near miss recording in the main dispensary had been sporadic in May 2019, with only four entries made. However, one near miss that occurred during the inspection was recorded immediately by the pharmacy technician.

Staff demonstrated that they had used caution stickers to reduce the risk of incorrect selection with allopurinol and amitriptyline tablets. Quetiapine tablets had been taken out of the alphabetical drug storage system to help reduce the incidence of picking errors. A list of common 'LASA' drugs was displayed in various locations in both dispensaries for reference. Staff usually marked prescriptions to alert staff to the risk of errors with these drugs; however, some prescriptions for quetiapine were not marked. One of the ACTs held regular team 'huddle' meetings to discuss patient safety learning points from near miss reviews and errors. 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. A list of activities that could not take place in the absence of the Responsible Pharmacist was displayed in the dispensary for reference. The ACTs explained that they could only check prescriptions that had previously been initialled by the pharmacist to show they had been clinically checked.

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. Cards displayed at the medicines counter asked customers to complete an online survey about customer care. 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 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.

The pharmacist had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary and available in the pharmacy duty folder and a safeguarding file. Staff had received in-house training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage the workload safely. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They can speak up about the way the pharmacy works.

Inspector's evidence

A regular part-time pharmacist was employed, but relief and locum pharmacists oversaw most of the pharmacy's professional activities. Pharmacists were assisted in the day-to-day operation of the pharmacy by the part-time store manager, a qualified dispensing assistant. Neither the regular pharmacist nor the store manager were present during the inspection.

There were enough suitably qualified and skilled staff present to comfortably manage the workload and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. A trainee dispensing assistant worked under the pharmacist's supervision.One of the accuracy checking technicians (ACTs) explained that it was his last week in store and said that another ACT had been recruited to replace him. Staff said that the company had been actively trying to recruit another regular pharmacist since December 2018 but had had no success to date.

Targets were set for MURs but staff said these were managed appropriately and did not affect the pharmacists' professional judgement or patient care. Staff said that there was no pressure to complete MURs if other issues took priority.Staff worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, store manager or Area Manager. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. They said that they would feel confident refusing a sale and had done so in the past when dealing with what they considered to be inappropriate requests for products containing codeine.

Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. The pharmacy technician had recently undertaken training on smoking cessation services as she was keen to begin providing these in the future. She said she understood the revalidation process and based her continuing professional development entries on training provided by the company. All staff were subject to twice-yearly performance and development reviews. They could discuss issues informally with the pharmacists or store manager whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow safe working. A spacious dispensary on the first floor was used to provide services to care homes. A smaller room on the same floor was used for the assembly and storage of MDS trays for community patients.

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 provides services that people can access 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 is particularly good at managing its substance misuse services. 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 other nearby pharmacies. Some health promotional material was on display in the retail area.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing. 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 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.

The pharmacy received some faxed prescriptions from local surgeries. Staff gave assurances that medicines were not supplied against unsigned faxes and that Schedule 2 or 3 CDs were only ever supplied against the original prescription. Patient information forms (PIFs) were added to each prescription to highlight any issues that needed to be brought to the pharmacist's attention before checking or at the point of handout such as patient eligibility for an MUR or counselling opportunities. Laminated cards were attached to prescriptions to highlight the fact that a CD or fridge line needed to be added before the prescription was handed out.

The pharmacy technician said that stickers or laminated cards were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. However, there was no evidence of this available and one prescription for gabapentin which was over 28 days old was not marked in this way. The pharmacy technician dealt with the prescription appropriately as soon as it was pointed out. Coloured cards were used to flag up prescriptions for high-risk drugs such as warfarin, methotrexate and lithium. 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 added to the patient medication record (PMR). However, results of the most recent high-risk medicines audit commissioned by the Local Health Board showed that 12 patients prescribed warfarin did not have a current INR result recorded on their PMR.

The pharmacy team were aware of the risks of valproate use during pregnancy. Results of the most recent high-risk medicines audit showed that one patient prescribed valproate in April 2019 who had met the risk criteria had been counselled and provided with patient information. An information pack for valproate patients was available in the main dispensary. A poster reminding staff of the actions to be taken when a patient meeting the risk criteria was prescribed valproate was displayed in the care home dispensary.

A text service was available: patients were sent a message to let them know their medicines were ready for collection. 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 were obtained for CDs. Separate signatures on paper forms were also obtained for deliveries to care homes. 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 MDS trays were used to supply medicines to a large number of patients. A Care Services PIF was attached to each prescription to relay information to the checking pharmacist or ACT, such as any new medicines, change of medicines or allergies. Trays were labelled with descriptions and patient information leaflets were routinely supplied. One MDS tray included paracetamol tablets, one four times a day, although the dose on the prescription stated: 'Take one to two tablets up to four times daily when required'. The dispensing assistant who had assembled the tray said that the dose in the tray had been taken from the most current hospital discharge letter. She said that she would ask the GP to change the dose on the prescription.

A list of community MDS patients was displayed on the wall for reference. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, contact details for representatives where appropriate and details of any messages or queries. Dedicated communications books were used to record all telephone calls relating to community MDS or care home services.

The substance misuse services were well-managed. There was a list of useful contact details available for local substance misuse agencies, individual keyworkers and self-help and support groups. A communications book was used to ensure continuity of the substance misuse service and included details of clients who had not attended for their dose. A notice advised supervised clients that this service was provided between 9am and 5pm from Monday to Saturday and between 10am and 1.30pm on Sundays.

Medicines were obtained from licensed wholesalers and were generally stored appropriately including those requiring cold storage. However, there was limited storage space for medicines in the main dispensary and some different products and different strengths of the same product were stored very closely together, increasing the risk of picking errors.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacy technician was able to describe how she would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier.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 capsule counters were used to count tablets and capsules. Staff said that they would wash these after 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.