General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Sycamore Street, NEWCASTLE EMLYN, Dyfed, SA38 9AP

Pharmacy reference: 1043312

Type of pharmacy: Community

Date of inspection: 30/01/2020

Pharmacy context

This is a high street pharmacy in a small rural town. The pharmacy sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides services including emergency hormonal contraception, 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 improve the safety and quality of pharmacy services
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 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 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 its staff receive training so that they know how to keep 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 analysis of dispensing errors and near misses. The non-pharmacist branch manager said that incorrect drug and strength errors had reduced dramatically since the introduction of the new Columbus pharmacy software programme about 18 months previously. The software allowed most prescription items to be scanned so that the drug field in the patient medication record could be populated directly from the barcode. If the wrong item was scanned, the system would not generate a label. The manager said that analysis of near misses showed that some quantity errors still occurred. As a result, staff were required to mark split boxes on all sides to reduce the risk of them being mistaken for original packs. 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 that all staff had read and signed. Staff were aware of the risks of errors with 'Look-Alike, Sound-Alike' or 'LASA' drugs. Lists of the most common LASA drugs were displayed at each labelling terminal for reference. Staff also marked prescriptions to further alert staff to the risk of errors with these drugs. 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 and these were regularly reviewed. During the pharmacist's lunch break, staff demonstrated that they understood the activities that could not take place in her absence by explaining to customers that they could not sell Pharmacy medicines or hand out prescriptions.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of a 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 at the medicines counter.

Evidence of professional indemnity insurance was available. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, alterations made to the RP register were not always accompanied by a clear audit trail. This meant that it might be difficult to fully resolve queries or deal with errors effectively. 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 checked weekly.

Staff received annual training on the information governance policy and had signed confidentiality agreements. 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. Notices displayed at the medicines counter and in the consultation room signposted people to the company website for information on the way in which personal data was used and managed.

The pharmacists had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. A summary of the chaperone policy was displayed on the consultation room door and inside the room itself. A poster in the staff room described the process that staff members should follow if they had safeguarding concerns about a colleague.

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. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

Two regular pharmacists worked at the pharmacy as part of a job-share. They were assisted in the day-to-day operation of the pharmacy by the branch manager, who was a trainee pharmacy technician. A locum pharmacist was working at the pharmacy on the day of the inspection. The support team consisted of three dispensing assistants, one of whom was absent. The manager said that she was currently recruiting for a customer assistant to work on Saturdays. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles and the trainee pharmacy technician worked under the supervision of the pharmacists.

Targets were set for MURs but these were managed appropriately by booked appointment. The branch manager said that the targets did not affect the pharmacists' professional judgement or compromise patient care. Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists or Area Manager. The organisation's process for raising concerns was displayed in the dispensary. It referred to the whistleblowing policy and staff said that they could access this via the company's intranet system.

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 on new products, clinical topics, operational procedures and services. Colleagues could access this training through the pharmacy's intranet system or via an app on their personal mobile phone. They also undertook regular paper-based learning and had recently completed a module on the management of diarrhoea. Staff were not subject to formal appraisals. The pharmacy manager said that she provided informal 'in-the-moment' feedback whenever the need arose, but this was not in the form of private one-to-one conversations. The lack of a structured performance and development programme might mean that opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was housed in an old building and some of the décor was in need of refreshment. It was fairly clean, tidy and well-organised, with enough space to allow safe working. A contracted cleaner arrived during the inspection to deep clean the store. The store manager said that the pharmacy was subject to a deep clean every six months. Some stock and prescriptions were being temporarily stored on the dispensary floor but did not pose a trip hazard.

The dispensary sink had only cold running water, but staff said that hot water was available in the kitchen and bathroom on the first floor. Soap and cleaning materials were available. A consultation room was available for private consultations and counselling, although it was not clearly visible from or advertised in the retail area. The lighting and temperature in the pharmacy were generally appropriate. The dispensary was a little cold, but it was a cold day.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at promoting the services it provides so that people know about them. But some people, such as wheelchair users, may have difficulty accessing services. If the pharmacy can't provide a service, it directs people to somewhere that can help. Its working practices are safe and effective. And its team members take extra care with high-risk medicines to help make sure that people use these safely. It generally stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a wide range of services that were appropriately advertised, although the locum pharmacist was unable to provide most locally-commissioned or All-Wales services that day. There was wheelchair access into the pharmacy. Staff said that the consultation room could be accessed by most wheelchairs, although on a recent occasion access had not been possible for a patient using a large electric wheelchair. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. Some health promotional material was displayed at the medicines counter. The branch manager said that the pharmacists had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the Choose Pharmacy common ailments service.

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 and insulin 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 dispensed medicines against many faxed prescriptions from local surgeries due to its rural location. The branch manager gave assurances that medicines were never supplied against unsigned faxes and that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Patient information forms were added to each prescription to highlight issues such as a patient's eligibility for an MUR, or to make notes to convey information to the pharmacist. The forms were crossed through or marked 'no messages' if there was no information to convey. 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. 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.

The pharmacy team were aware of the risks of valproate use during pregnancy. The branch manager said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. She explained that information was attached to original packs of valproate and could be printed from the company intranet if the medicine was not supplied in its

original pack. 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 messaging service was available to let patients know their medicines were ready for collection. Prescriptions awaiting collection were marked with five different coloured stickers that corresponded to specific weeks. Staff said that they remained in the retrieval area for about two months before the patient was contacted as a reminder. After a further week the medicines were returned to stock if uncollected. Some dispensed medicines were stored in an area that customers passed through if they needed to access the consultation room. There was a risk that this could compromise the security of these medicines. However, the branch manager said that customers would always be escorted through this area to the consultation room by a member of staff to prevent unauthorised access.

The pharmacy provided a prescription delivery service for a charge. The 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. In the event of a missed delivery, the delivery driver put a notification card through the door and brought the prescription back to the pharmacy.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. The compliance aids were labelled with descriptions. However, these did not always include enough detail to enable identification of individual medicines, with many described simply as: 'round white tablet'. There was a risk that the patient would not have all the information they might require for them to make informed decisions about their own treatment. Patient information leaflets were routinely supplied. A dedicated communications book for compliance aid trays was used to record messages and queries. A list of patients and their collection or delivery arrangements was displayed in the dispensary for reference. 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 changes and any relevant documentation, such as copies of repeat prescription order forms. A progress log for all patients was displayed and showed the status of each patient's tray at any given time.

The pharmacy had carried out approximately 100 influenza vaccinations during the 2019/20 season. The branch manager said that these had been split evenly between the private and NHS enhanced services. She said that the branch was due to begin providing a new private cystitis test and treat service in the next few weeks.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock.

All 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 which was checked at the beginning and end of each day. During the inspection, a patient returned some dispensed ramipril capsules that were broken. The pharmacist replaced the affected capsules and prepared to send these back to the manufacturer for investigation. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive. However, the branch manager said that they were not currently compliant and were awaiting instruction from the superintendent's office on how to proceed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It makes sure these are always safe and suitable for use. It generally uses 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. 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 generally used to protect the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling. However, access to the consultation rom was through a part of the dispensary where dispensed prescriptions were stored. No details of prescribed medicines could be seen, but names and addresses were clearly visible on prescription bags, which might compromise the privacy of patients receiving pharmacy services. The pharmacy manager said that she would order deeper storage trays for dispensed prescriptions to ensure that no details were visible and would use a screen in the meantime as a temporary measure. Following the inspection, she sent photographs of a curtain that had been installed for this purpose.

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.