General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 8-10 Dimond Street, Pembroke Dock, PEMBROKE, Dyfed, SA72 6AH

Pharmacy reference: 1043319

Type of pharmacy: Community

Date of inspection: 17/09/2024

Pharmacy context

This pharmacy is in a town centre in South West Wales. It sells a range of over-the-counter medicines and dispenses both NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the same company. The pharmacy offers a wide range of services including provision of emergency hormonal contraception, treatment for minor ailments and smoking cessation services. 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	1.8	Good practice	Safeguarding is an integral part of the culture of the pharmacy.
2. Staff	Standards met	2.2	Good practice	Pharmacy team members have the appropriate skills, qualifications and competence for their roles 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	4.2	Good practice	The pharmacy has robust systems in place to ensure that people prescribed higher risk medicines are appropriately counselled.
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 reduce the risk of similar mistakes happening again. The pharmacy keeps the records it needs to by law. Pharmacy team members keep people's private information safe. And they are good at recognising and reporting 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 electronic recording and monthly analysis of dispensing errors and near misses. The pharmacy manager explained that incorrect drug and strength errors had reduced dramatically since the introduction of the current pharmacy software system. 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. Some items could not be scanned, and in these cases the dispenser selected the system's 'no barcode' option, wrote 'NB' next to the item on the prescription as an audit trail, and notified the accuracy checker that the selected item had not been confirmed as correct. However, analysis of near misses showed that some quantity errors still occurred. To help reduce the incidence of these, the pharmacy team had been asked to circle quantities on original packs, or write the quantity supplied on the inside flap of split packs, to show that they had been double-checked. The risks associated with the influenza vaccination service had been assessed and posters describing the processes to follow in the event of needlestick injury and anaphylaxis were displayed in the consultation room.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team had completed an online declaration and assessment for each SOP. They were able to describe their roles and responsibilities. A pharmacy technician who worked as an accuracy checker explained that she could check all prescription items that had been marked as clinically checked by a pharmacist, as long as she had not been involved with dispensing or labelling these. A dispensing assistant described the activities that could not take place in the absence of the responsible pharmacist.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A message on each prescription bag encouraged customers to complete an online survey about customer care. Results of these surveys were sent directly to the pharmacist manager, who explained that she acted on any feedback where necessary. A formal complaints procedure was in place, and this was advertised in the practice leaflet displayed in the retail area.

Evidence of current professional indemnity insurance was available. Records were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. CD running balances were checked frequently.

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 identifying confidential waste and disposing of it appropriately. A privacy notice

displayed behind the medicines counter described the way in which data was used and managed by the pharmacy, although the notice was not easy to see from the retail area. The pharmacist and pharmacy technicians had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available in the dispensary. And they were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. A summary of the pharmacy's chaperone policy was advertised in the consultation room. A poster in the pharmacy advertised the 'Safe Space' domestic abuse scheme and included details of a confidential helpline.

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

The regular pharmacist worked at the pharmacy on most days. He was assisted on some days each week by a relief pharmacist employed by the company. The pharmacy team consisted of two pharmacy technicians, one of whom was a qualified accuracy checker (ACT), five dispensing assistants (DAs), one of whom was employed as the store manager and oversaw the operational running of the branch, and a trainee healthcare assistant who worked on the medicines counter every Saturday. The trainee worked under the supervision of the pharmacist or other trained members of the pharmacy team. Relief DAs employed by the company and an ACT from another nearby branch were available to cover team members' absences. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacists on several occasions for further advice on how to deal with transactions. Team members undertook regular online training provided by the organisation on clinical topics, operational procedures and services. The company had a formal appraisal system in place and team members received a performance and development review every six months. They also discussed performance and development issues informally with the regular pharmacist whenever the need arose.

Targets were set for certain services, but these were managed appropriately, and the pharmacists said that they did not affect their professional judgement or compromise patient care. Pharmacy team members worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, pharmacy manager, area manager and other members of the company's senior management team. A whistleblowing policy was available on the pharmacy's intranet system. It included a confidential helpline for raising concerns outside the company. The pharmacy manager printed this out and displayed it in the dispensary for reference.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure, with enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. Some stock medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use.

A consultation room was available for private consultations and counselling, and this was clearly advertised. A semi-private hatch that opened into the dispensary from a quiet part of the retail area was sometimes used by people to access the supervised consumption service. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. Its working practices are safe and effective. It has robust systems in place to ensure that people prescribed higher risk medicines are appropriately counselled. 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 team offered a range of services, which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members used large print dispensing labels for people with poor eyesight. They signposted people requesting services they could not provide to nearby pharmacies or other healthcare providers such as local GP surgeries and opticians.

About a third of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. A notice at the medicines counter advised people that their medicines might be assembled offsite. The hub pharmacy could not assemble split packs, fridge lines, cytotoxic medicines, bulky items, controlled drugs requiring safe custody or multi-compartment compliance packs and these continued to be dispensed at the branch.

The pharmacy team had a good relationship with local GP surgery teams, which meant that queries and problems were usually dealt with quickly and effectively. Dispensing staff used baskets to ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were initialled by the dispenser and accuracy 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 the team who had been involved in the dispensing process. The pharmacy manager explained that if an item was owed, a second stamp was added to the prescription to allow the same audit trail to be applied to the owing item. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow pharmacy team members to check these items at all points of the dispensing process. This helped to reduce the risk of a person receiving the wrong medicine. Bag labels attached to dispensed medicines awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know their medicines were ready for collection.

Dispensed medicines awaiting collection were assigned to specific storage locations in the dispensary. When pharmacy team members needed to locate a prescription, the patient's name was typed into a handheld device and this brought up a list of locations in which their items were being stored, including medicine fridges or the CD cabinet where applicable. The software system also alerted team members if the pharmacist wished to speak to the patient or their representative at the point of handout. It displayed a message on the handheld devices which team members were required to acknowledge and action before the handout process could be completed. 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. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

The pharmacy's software system identified people prescribed higher-risk medicines such as warfarin,

lithium and methotrexate. It required pharmacy team members to ask people questions about relevant blood tests and dose changes before the handout process could be completed on the system. The information obtained was recorded on the patient medication record. Team members were aware of the risks of using valproate-containing medicines and topiramate during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The pharmacy manager said that some people prescribed valproate who met the risk criteria had been identified. She explained that they were routinely counselled and provided with information, and alerts had been added to their patient medication records. Steroid cards, valproate information, alitretinoin information and warfarin monitoring booklets were available to provide to patients.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. People requesting the service were risk-assessed for suitability. Compliance packs were labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details, collection or delivery arrangements and details of any messages or changes for communication purposes. A list of people receiving their medicines in compliance packs was available for reference. A progress log was also available and showed the status of each person's compliance pack at any given time. An original pack and medication administration record (MAR) dispensing service was also provided to some people in the community.

A technician-led discharge medicines review service was provided, and uptake of this was steady. Uptake of the pharmacy's common ailments service, sore throat test and treat service, UTI (urinary tract infection) service and smoking cessation (supply and monitoring) service was high, as the pharmacy received frequent referrals from GP surgeries, opticians and the local health board's smoking services team. Demand for the emergency supply of prescribed medicines service was steady. However, there was a rise in demand during the summer months when numbers of visitors to the area increased. The pharmacy offered an EHC (emergency hormonal contraception) and bridging contraception service, a seasonal influenza vaccination service and a private pneumonia vaccination service. A supervised consumption service and a needle and syringe provision service were also available, as was a needle and syringe disposal service for people receiving treatment for chronic conditions.

The pharmacy provided a prescription collection service from four local surgeries. It also offered a medicines delivery service. Each prescription for delivery was scanned into an electronic device, and patients or their representatives signed the device to acknowledge receipt of the delivery as an audit trail. The device alerted the delivery driver if a controlled drug or a fridge line was included in the delivery so that they could notify the recipient. In the event of a missed delivery, the delivery driver put a notification card though the door and usually brought the medicines back to the pharmacy. However, they were sometimes returned to the delivery drivers' hub branch in Haverfordwest and were not taken back to the pharmacy until the following day. The pharmacy manager explained that the original prescription was retained in the pharmacy and could be re-dispensed if a person wanted to collect their medicines before they had been returned to the store, although this rarely happened.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some medicines that had been removed from their original packaging were not marked with their batch number or expiry date, which could make it difficult for the pharmacy to respond effectively to a query or safety recall. The pharmacy manager explained that this was an oversight and disposed of the medicines appropriately. Medicines requiring cold storage were kept in a large, well-organised medical fridge. Maximum and minimum temperatures for the fridges were usually checked and recorded daily, although there were occasional gaps in the records. This might make it difficult for the pharmacy team to be assured that these medicines were safe and fit for purpose. Recorded temperatures were

consistently within the required range. CDs were stored in three well-organised CD cabinets and obsolete CDs were kept separately from usable stock.

Medicine stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and recalls via its NHS email account and its intranet system. These communications were printed and filed for reference. The pharmacy team described how they had dealt with a medicine recall for Evorel Sequi patches that morning by quarantining affected stock and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And 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 to prevent cross-contamination, and these were clearly marked. Triangles were used to count loose tablets and were washed after being used to count 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 electrical equipment had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy. Bags of dispensed medicines 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.