General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 72-74 John Street, PORTHCAWL, Mid Glamorgan, CF36 3BD

Pharmacy reference: 1043622

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

This is a high street pharmacy in a small seaside town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides medicines in multi-compartment compliance aids to a large number of patients who live in the surrounding area. It offers a range of 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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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 generally 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 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 recording and monthly analysis of dispensing errors and near misses. Only six near misses had been recorded for the previous month and it was possible that some incidents had not been captured. However, the pharmacist 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 errors were quantity or labelling mistakes. Staff said that these mistakes were often caused by distractions such as answering the telephone and serving customers and this issue had been discussed during a monthly staff meeting. As a result, all staff had agreed that if actively dispensing they would focus on the task in hand to reduce risk. However, computer issues meant that staff were only able to label prescriptions using the terminal at the front medicines counter for a period during the inspection and were often interrupted by customers, increasing the risk of errors.

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. The most recent issue was displayed on the dispensary noticeboard for reference. Staff demonstrated that following a direction from the superintendent's office to put extra safety measures in place for 'Look-Alike, Sound-Alike' or 'LASA' drugs that were repeatedly the subject of patient safety incidents, they had used caution stickers to reduce the risk of incorrect selection. They said they also marked prescriptions to further alert staff to the risk of errors with these drugs, although some prescriptions in the retrieval system were not marked in this way. A list of common 'LASA' drugs was displayed at each labelling terminal. 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. Staff were in the process of reading and signing new versions of some SOPs. There had recently been a focus on the SOP for prescription handout and a message on the patient safety noticeboard in the dispensary reminded staff to check each patient's postcode at the handout stage. Observation confirmed that all staff were following this instruction. Staff said that the accuracy checking technician (ACT) was able to check any prescriptions that had been stamped and initialled by a pharmacist as evidence 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. Leaflets advertising the NHS complaints procedure 'Putting Things Right' were also displayed in the retail area.

Evidence of current professional indemnity insurance was available. There was evidence that most necessary records were kept and properly maintained, including responsible pharmacist (RP), specials procurement and controlled drug (CD) records. However, electronic records of private prescription and emergency supply records could not be viewed and so it was not possible to be certain that they were kept and maintained appropriately, The pharmacy's computer system showed an error message each time the pharmacist attempted to access the records and the problem could not be resolved during the inspection. The pharmacist said that she would report this to the maintenance team. She was able to demonstrate the way in which a private prescription record would be entered onto the system. There was a facility to create prescriber details if necessary and a field for adding the nature of the emergency to emergency supply records.

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 system.

The pharmacists had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had received in-house training. The pharmacist said that she had recently contacted the police following concerns about the safety of a young girl accessing the EHC service. The police had attended the pharmacy and managed the situation. A summary of the company's chaperone policy was advertised in a poster displayed near the consultation room entrance and inside the room itself. Leaflets with information about living with dementia and children's mental wellbeing were displayed at the medicines counter. Leaflets with information about local benefits and services for carers were displayed in the retail area.

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 professional activities on four days each week together with a second pharmacist. They were assisted by the branch manager, a qualified dispensing assistant. 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. The support team consisted of an accuracy checking technician, who was absent, a pharmacy technician, eight dispensing assistants and three medicines counter assistants. Staff members had the necessary training and qualifications for their roles. Three 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.

Targets were set for MURs but these were managed appropriately and the pharmacist said that they did not affect her professional judgement or compromise 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 pharmacists, store manager or Area Manager. They were aware that a whistleblowing procedure for reporting concerns outside the organisation could be accessed via the pharmacy intranet.

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. They completed regular paper-based assessments to reinforce this training. They also had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. All staff had recently completed training provided by NHS Wales on improving the quality of services provided. The pharmacy technicians were subject to six-monthly performance and development reviews and other staff had annual one-to-one interviews to discuss their training and development needs. All staff 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 separate room in the pharmacy basement was used for the assembly of MDS trays. 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 generally safe and effective. It sources and stores medicines safely and carries out some checks to help make sure that medicines are in good condition and suitable to supply.

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. A machine positioned at the rear of the retail area measured customers' weight, height, BMI and body fat for a small charge. The pharmacists had recently visited the local surgery to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around the repeat dispensing service, the DRM service, high-risk medicines audits and the 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 requiring safe custody 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. A text message service was available to let patients know their medicines were ready for collection.

Patient information forms (PIFs) 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. If there was no information to convey then a pre-printed 'No Messages' PIF was used. Coloured cards were attached to prescriptions to highlight the fact that a CD or fridge line needed to be added before a prescription was handed out, or that the pharmacist wished to speak to the patient or their representative at the point of collection. The pharmacist said that Schedule 3 and 4 CDs that did not require safe custody were usually marked by writing the prescription's expiry date on the PIF. This was to ensure that they would not be supplied after a prescription had expired, However, one prescription for diazepam and another for pregabalin were found present that had not been marked in this way and both were over 28 days old, so no longer valid. There was a risk that the dispensed medicines might be supplied to patients against an invalid prescription. The pharmacist said this was an oversight and removed the prescriptions from the retrieval system.

Coloured cards or marked PIFs were used to flag up prescriptions for high-risk drugs such as warfarin, lithium and methotrexate. The cards 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). However, one prescription for warfarin was found present that had not been marked in any way. This demonstrated that the process in place for identifying patients prescribed high-risk medicines was not sufficiently robust and there was a risk that opportunities to counsel patients might be missed.

The pharmacy team were aware of the risks of valproate use during pregnancy. A summary of the NICE guidance and safety advice for valproate was displayed in the dispensary. The pharmacist said that patients prescribed valproate who had met the risk criteria had been counselled and provided with patient safety information that 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.

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. 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.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a large number of patients. These medicines were assembled in a dedicated room in the basement which was well-organised, with designated areas for different tasks. Trays were labelled with descriptions, although these did not always include enough detail to enable identification of individual medicines. Patient information leaflets were routinely supplied. A communications book was used to record all telephone calls, enabling messages and queries to be dealt with efficiently. A progress log for patients was displayed and showed the status of each patient's tray at any given time. It included the patient's name, date of birth, collection and delivery details and dates for each stage of progress. Each patient had a section in a file that included patient and medication details, collection and delivery details, details of any messages or queries and any relevant documentation such as discharge letters and current repeat prescriptions. One patient received warfarin in compliance aid trays. The team explained that the surgery faxed through information about INR results and current dosages before the patient's monthly trays were assembled and these faxes were stored in the patient's file section for reference. They said that if another test was due before the next set of monthly trays they and the patient's family were contacted by the anticoagulant clinic with further information. Arrangements were made for new trays to be provided if the dosage had changed. Patients or their representatives were required to sign a docket when collecting compliance aid trays as an audit trail.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in three 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. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacy received drug alerts and recalls via email. The pharmacist 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. Drug recalls were printed, filed and signed to show that they had been actioned. A poster advertising a recent patient-level recall for Vimpat and Neupro products was displayed behind the medicines counter. 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 to 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. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. However, the pharmacy's computers crashed during the inspection, preventing labels from being generated for about half an hour before the problem was fixed. Staff said that this had also happened during the previous week and staff had been unable to generate labels for several hours. Equipment and facilities were 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. Some 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.