

Registered pharmacy inspection report

Pharmacy Name: Boots, 118 Dunraven Street, TONYPANDY, Mid Glamorgan, CF40 1AS

Pharmacy reference: 1043636

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This is a high street pharmacy in a small town. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. The pharmacy sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides services including emergency hormonal contraception, 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

Follow this link to [find out what the inspections possible outcomes mean](#)

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	Good practice	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles and are supported to address their learning and development needs
		2.5	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	4.2	Good practice	The pharmacy has robust systems in place to ensure that patients prescribed high-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 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 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 analysis of dispensing errors and near misses. However, they said that incorrect drug and strength errors had reduced dramatically since the very recent introduction of the new Columbus pharmacy software programme. The software allowed many 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 pharmacist said that there had been a change in the dispensing process after several near misses involving incorrect quantities. Staff now marked split boxes on all sides to help distinguish them from original packs. The pharmacist said that she had also trained each member of dispensing staff individually on the most, common unusual pack sizes. 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 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, they had created boxes with caution stickers on and placed these on top of stock. The act of picking up the box to reach the stock underneath alerted staff and helped to avoid picking errors. Staff also marked prescriptions to further alert staff to the risk of errors with these drugs. Lists of the most common LASA drugs were displayed at each labelling terminal for reference. 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. A list of daily tasks was displayed in the dispensary. Staff were able to describe the activities that they could not carry out in the absence of the responsible pharmacist.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of a recent survey displayed in the dispensary 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 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, the responsible pharmacist register had not been completed that day to show the time at which the pharmacist had taken charge of the safe and effective running of the pharmacy. The pharmacist remedied this as soon as it was

pointed out. Electronic 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 they did not include the nature of the emergency. CD running balances were typically checked weekly. However, the register for Physeptone SF 1mg/ml oral solution had not been subject to a balance check since 2018. The pharmacist said that this was an oversight as the product was no longer used.

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. A notice displayed at the medicines counter signposted people to the company website for information on the way in which personal data was used and managed.

The pharmacist and pharmacy technician had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had undertaken level one training and were able to identify different types of safeguarding concerns. All staff were trained Dementia Friends. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

Principle 2 - Staffing ✓ Good practice

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

A regular pharmacist manager worked at the pharmacy on most days. Her role was covered by a relief pharmacist on alternate Wednesdays and Saturdays. The support team consisted of a pharmacy technician and two dispensing assistants who worked well together. Another dispensing assistant was absent. 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.

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 said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or Area Manager. A copy of the company's whistleblowing policy for reporting concerns was displayed in the pharmacy's office. Staff said that they had all been given a copy of the policy for their own reference.

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 had recently completed training on the pharmacy's new patient medication record (PMR) system. They had also completed recent paper-based assessments on the SOPs for high-risk medicines and the compliance aid and MAR chart services. All staff were subject to quarterly performance and development reviews. They could informally discuss issues with the pharmacist 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 generally protects people's privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised. The dispensary was small, but there was enough space to allow safe working. Some stock and prescriptions were being temporarily stored on the floor but did not pose a trip hazard.

The sink 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. A semi-private hatch that opened into the dispensary from a quiet part of the retail area was used by substance misuse clients. However, seats situated near the hatch increased the risk that the privacy of clients could be compromised. The pharmacist said that she offered clients use of the consultation room if there were customers seated near the hatch. 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. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. Its team members take extra care with high-risk medicines to help make sure that people use these safely. It stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a wide range of services that were appropriately advertised. There was a small step up to the pharmacy entrance, but staff said that a portable ramp was available. There was wheelchair access into the consultation room. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. Some health promotional material was displayed in the retail area.

The pharmacist said that about 60% of the pharmacy's prescription items were dispensed at the company's hub pharmacy. A notice at the medicines counter informed people of this arrangement. Dispensing staff used baskets 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.

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. 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. Patient information forms were marked to identify dispensed Schedule 3 and 4 CDs awaiting collection and included the date after which the prescription was invalid and could no longer be supplied. A text messaging service was available to let patients know their medicines were ready for collection.

The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that patients prescribed valproate who met the risk criteria had been counselled and provided with appropriate information. The information pack for valproate patients could not be located, but the pharmacist demonstrated that she could access and print this information via the internet. 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 pharmacy charged patients to use the delivery service. It 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 through 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. Staff said that all new patients requesting the service were assessed for suitability. Compliance aids were labelled with descriptions to enable identification of individual medicines. The pharmacist said that patient information leaflets were routinely supplied, although there were no examples of this available. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, details of any messages or queries and any relevant documentation, such as repeat prescription order forms.

The substance misuse service was managed well. Clients were allocated a section in a dedicated file which included their prescription, a copy of their signed treatment agreement, their personal details, details of any notes or messages and relevant documents such as letters of authorisation. A list of clients that included their date of birth, contact details, supervision or collection details and other relevant notes was available at the front of the file.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some loose blister strips that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication. This increased the risk of error and did not comply with legislative requirements. 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. Storage space in the fridges was limited and some different products and different strengths of the same product were often stored very closely together, increasing the risk of errors. However, staff said that the Columbus software system would identify most incorrectly-selected items at the point of scanning. CDs were stored appropriately in a well-organised CD cabinet 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. Staff were able to demonstrate that they had dealt appropriately with recent drug recalls for Emerade injections and ranitidine tablets. Affected stock had been quarantined and was waiting to be sent back to the supplier. 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, it had not yet begun to check or decommission medicines.

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. 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 and these were clearly segregated. Triangles and a capsule counter were used to count tablets and capsules. Staff said that they would wash these after use with 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 pharmacy software system was protected with a password 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.