General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 77-79 Albany Road, Roath, CARDIFF, South Glamorgan, CF24 3LN

Pharmacy reference: 1043664

Type of pharmacy: Community

Date of inspection: 13/06/2022

Pharmacy context

This is a high street pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a wide range of 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

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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	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
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 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 electronic recording and the written monthly analysis of dispensing errors and near misses. The most common error involved incorrect quantities: the dispensing procedure had been changed as a result and staff now circled quantities on dispensing labels to show that they had been double checked. The pharmacist said that selection errors had reduced dramatically since the introduction of a new pharmacy software programme, which allowed most prescription items to be scanned so that the drug field in the patient medication record (PMR) could be populated directly from the barcode. If the wrong item was scanned, the system would not generate a label. However, the pharmacist explained that barcodes for about 7% of all prescription items could not be scanned. This had led to some selection errors and action had been taken as a result: staff now marked prescriptions that included items which could not be scanned as 'NB' (or 'no barcode'). This alerted the pharmacist to be extra vigilant when carrying out the accuracy check, as the item had not been verified through the scanning process.

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 staff had read and signed.

A recent bulletin from the superintendent's office included an article about the safety of valproate and pregabalin in pregnancy, a clinical update on hydroxychloroquine and chloroquine, and a case study focusing on patient safety incidents involving vulnerable patients. The risks associated with the influenza and pneumonia vaccination services 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 standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Paper copies of the SOPs were available in the dispensary and could also be accessed online. Pharmacy team members were in the process of reading and completing online declarations and assessments for updated versions of SOPs. A list of daily tasks was displayed in the dispensary, along with a list showing specific responsibilities assigned to each member of staff. Pharmacy team members were able to clearly describe their roles and responsibilities when questioned. The responsible pharmacist notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out to him.

Cards asking people to complete an online survey about customer care were handed to customers at the medicines counter and attached to some prescription bags. A formal complaints procedure was in

place and information about how to make complaints was included in a Boots Patient Guide leaflet, available in the consultation room. A poster in the consultation room advertised the local Community Health Council's complaints advocacy service. A leaflet advertising the NHS complaints service 'Putting Things Right' was also available.

Evidence of current professional indemnity insurance was available. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply and controlled drug (CD) records. However, 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 always include the nature of the emergency. This means that there might not be enough information available to allow the pharmacy team to fully resolve queries or deal with errors effectively. The pharmacy team could not find any current records of unlicensed specials but were able to describe the requirements for records to be marked with patient details and retained for five years. CD running balances were typically checked weekly or fortnightly.

Staff had received 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 leaflet about the Boots repeat prescription service displayed at the medicines counter included information about how and when patient data was recorded and shared. It signposted people to the company's privacy policy which was available online.

The pharmacist and staff had undertaken formal and in-house safeguarding training and had access to guidance and local contact details that were available in the dispensary. A chaperone policy was advertised in a poster displayed inside the consultation room. Information about support groups and services for carers was also available in the consultation room. A poster detailing the process to be followed by staff when providing the 'Ask for Ani' domestic abuse support service was displayed on the dispensary noticeboard for reference. A poster in the consultation room advertised the pharmacy's involvement in the national 'Safe Space' domestic abuse campaign and listed relevant helplines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and understand their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

Two pharmacists worked at the pharmacy as part of a job-share. Their support team usually consisted of a pharmacy technician and two dispensing assistants, one of whom was absent at the time of the inspection. The store manager was also a qualified dispensing assistant and was able to help in the dispensary if the team was very busy or short-staffed. A pharmacy student worked in the dispensary at weekends and had been enrolled on a dispensing assistant training course. A healthcare advisor was trained to work on the medicines counter when required. Staff members had the necessary training and qualifications for their roles. The pharmacy student worked under the supervision of the pharmacist and other trained members of staff. There were enough suitably qualified and skilled staff present to manage the workload during the inspection and the staffing level appeared adequate for the services provided.

There were no specific targets or incentives set for the services provided. Staff worked well together and said that they were happy to make suggestions within the team. They said that they felt comfortable raising concerns with the pharmacists or store manager. A whistleblowing policy was available on the 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 transactions. The pharmacy had frequent requests for over-the-counter products containing codeine but staff said that they would feel confident in refusing a sale, and had done so in the past when dealing with what they considered to be an inappropriate request for a codeine product.

Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. The pharmacy technician had recently completed an e-learning module on the OTC oral contraceptive desogestrel. All staff were subject to quarterly performance and development reviews, although the pharmacy technician said that his current appraisal was overdue. 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 generally protects people’s privacy.

Inspector's evidence

The pharmacy was fairly clean and tidy. The dispensary was small but well-organised and there was enough clear bench space for safe working. Some stock and dispensed prescriptions awaiting collection were 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. Hand sanitiser was available for staff use. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers.

A locked consultation room was available for private consultations and counselling and its availability was clearly advertised. A hatch that opened into a semi-private part of the retail area at the back of the shop was used by substance misuse and needle exchange clients. A seat situated near the hatch increased the risk that the privacy of these clients could be compromised. However, clients were offered the 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 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 safe and effective. It stores medicines appropriately and carries out 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 wheelchair access into the pharmacy and consultation room. A signposting directory provided by the local health board was available in the dispensary and staff regularly signposted people requesting services they could not provide to other local pharmacies or healthcare services, such as local GP surgeries and a nearby optician. A list of local sexual health clinics was displayed in the consultation room and a written record showed that a person had recently been signposted to a sexual health clinic when the pharmacy team had been unable to help them. Some health promotional material was on display in the retail area. Members of the pharmacy team had visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. These visits had involved discussions around the influenza vaccination service, repeat dispensing service and the Choose Pharmacy common ailments service.

The pharmacist explained that due to a technical failure the dispensing software system had recently been inaccessible for a day, which had created a significant backlog of work. This, coupled with the fact that the team were short-staffed as one full-time dispenser was absent, meant that people with walk-in prescriptions had to wait longer than usual. They were told that their prescription would take between 15 and 30 minutes to be processed and were given the option to wait, call back or have their prescription delivered.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and dispensing labels were initialled by the dispenser and checker to provide an audit trail. A four-way stamp used on each prescription was also initialled by all members of staff that had been involved in the dispensing process. Controlled drugs 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. The pharmacy dispensed medicines against many faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

A Pharmacist's Information Form (PIF) was attached to some prescriptions to relay information to the checking pharmacist, such as any new medicines, changes of medicines or allergies. Coloured cards were attached to dispensed prescriptions to highlight the fact that a paediatric medicine was included in the bag, or that a CD or fridge line needed to be added before the prescription was handed out. 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 helped ensure that these prescriptions were checked for validity before handout to the patient. A text messaging service was available to let patients know when their medicines were ready for collection. Each bag label attached to a prescription awaiting collection included a barcode that was scanned as it was placed in the prescription retrieval

area. The pharmacy team used this data to generate printed reports of uncollected items, which showed each prescription's expiry date and whether it included a redeemed owing. This allowed the team to manage uncollected items appropriately and ensured that there was always enough storage space for current prescriptions.

Coloured cards were used to flag up prescriptions for high-risk drugs such as warfarin, lithium and methotrexate: the pharmacist said that information from the recipient was recorded on the patient medication record (PMR). The pharmacist demonstrated that an INR had recently been recorded for a patient prescribed warfarin and said that a patient taking lithium tablets had provided the pharmacy with their last blood test result for information.

The pharmacy provided a prescription collection service from about 20 surgeries in the area. It also offered a prescription delivery service. Deliveries were logged onto an electronic system that both the pharmacy team and delivery drivers could access. A patient due to receive a delivery that day was telephoned beforehand to ensure that they would be at home and given a time window for delivery. Notes or messages could be added to the delivery schedule for the driver's information. The schedule was annotated to alert a driver if a controlled drug or fridge line was included in the package. Signatures 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 a range of services. There was a high uptake of the All-Wales EHC service, which was linked to the large local student population. There was also a high uptake of the common ailments and smoking cessation services. The pharmacy provided services to several substance misuse clients and managed them well. Medication for each client was prepared in advance and stored in the relevant labelled section of a dedicated CD cabinet. Each client had a designated section in a file that was used to hold prescriptions, supervised consumption claim forms and any other relevant information or messages.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some tablets that had been removed from their original packaging and some pre-packed methadone doses were not adequately labelled either as stock or named-patient medication, which increased the risk of errors. Medicines requiring cold storage were stored in a large, well-organised drug fridge. Maximum and minimum temperatures were usually recorded daily, although there were some gaps in the current month's records. Recorded temperatures were consistently within the required range. CDs were stored in three well-organised CD cabinets. Obsolete CDs were segregated from usable stock. A cabinet containing general CD stock was open with the key in the door when the inspection began, compromising the security of these medicines. The pharmacist removed the key and secured it on his person shortly afterwards.

Stock was subject to regular documented expiry date checks. One bottle of Acular eye drops that had been returned to dispensary shelves after being labelled for a patient but not collected was found to be out of date. However, staff and the pharmacist said that an expiry date check formed part of their dispensing and checking processes. 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 pharmacist was able to describe how he would deal with medicines or medical devices that were unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier.

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. Triangles and a capsule counter were used to count most tablets and capsules and were washed after use. The pharmacy technician explained that he usually counted loose cytotoxic tablets by tipping them into the cap of the stock container, counting them and putting the required number into a dispensing bottle. 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.