General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit D, Cardiff Bay Retail Park, Ferry Road, CARDIFF, South Glamorgan, CF11 0JR

Pharmacy reference: 1043703

Type of pharmacy: Community

Date of inspection: 23/10/2023

Pharmacy context

This is a pharmacy situated in a retail park. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. 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

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	N/A	N/A	N/A
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 keeps the records it needs to by law. It asks people to give their views about the services it provides. Pharmacy team members receive training so that they know how to keep people's private information safe. And they 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 monthly analysis of dispensing errors and near misses. The branch 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. The manager said that analysis of near misses showed that some quantity errors still occurred. As a result, staff were required to circle quantities on packaging to show that these had been double checked as correct. However, this had not resolved the issue completely and the branch manager said that she and the pharmacists were currently exploring other ways to reduce the incidence of quantity errors. Weekly 'huddle' meetings were held to discuss current issues, including learning points from dispensing incidents. 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. Posters describing the processes to follow in the event of needlestick injury, fainting, anaphylaxis and seizures 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. A dispensing assistant was able to describe the activities that could not take place in the absence of the responsible pharmacist. The accuracy checking technician (ACT) could check most prescription items that had been clinically checked by a pharmacist if she had not been involved in dispensing or labelling the item. Prescriptions that were considered suitable for an ACT accuracy check were marked with a stamp and initialled by the pharmacist to show that they had been clinically checked. The ACT then initialled the prescription after she had performed the accuracy check. The responsible pharmacist notice displayed was incorrect and the pharmacist remedied this as soon as it was pointed out to him.

Cards displayed at the medicines counter encouraged customers to complete an online survey about customer care. Results of these surveys were sent directly to the branch manager. She said that feedback about the service provided by the pharmacy was mostly positive and produced recent examples to reinforce this. A formal complaints procedure was in place and information about how to make complaints was included in the pharmacy's practice leaflet which was displayed in the retail area.

Evidence of current professional indemnity insurance was available. All necessary records were kept and were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were checked weekly by the ACT or a pharmacist.

Staff received annual training on the information governance policy and had signed confidentiality agreements. They were able to identify confidential waste and understood how to dispose of it appropriately. A dispensed prescription was being temporarily stored on the pharmacy riser and patient details could be seen from the retail area, which might compromise confidentiality. The branch manager said that this was an oversight and ensured that all confidential information was moved from the area as soon as this was pointed out.

The pharmacists and ACT had undertaken formal safeguarding training. All team members had received internal training and had access to safeguarding guidance and local safeguarding contact details that were available in the dispensary. The pharmacy team had been trained to provide the 'Safe Spaces' and 'Ask for Ani' domestic abuse services, although they had not yet had any requests for these. Information about the 'Ask for Ani' service was available in a folder in the dispensary. Posters advertising both services were displayed inside the consultation room, as was a summary of the pharmacy's chaperone policy. Members of the pharmacy team working at the medicines counter or in a patient-facing role in the dispensary wore body cameras which they could use to record video footage of interactions with the public. This helped to safeguard team members against aggressive or violent behaviour.

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

Inspector's evidence

Three pharmacists worked at the pharmacy as part of a job-share. Their absences were covered by relief pharmacists employed by the company or locum pharmacists. The pharmacists worked in shifts which usually overlapped, allowing them to have a handover period to ensure continuity of service when shifts changed. A qualified dispensing assistant (DA) was employed as the branch manager. Her role was mainly administrative, but she sometimes worked in the dispensary or on the medicines counter if the team needed help. The support team consisted of four DAs (one of whom was also employed as an assistant branch manager), a trainee DA and a pharmacy student who was employed on a zero hours contract. An accuracy checking technician (ACT), four DAs and a trainee DA were absent. During periods when the store was closed but the pharmacy remained open, the staffing profile consisted of a pharmacist and one other team member. This was adequate as the team dealt with one customer at a time using an intercom system and a secure hatch at the pharmacy entrance. There were enough suitably qualified and skilled team members present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. The trainee DA and the pharmacy student worked under the supervision of the pharmacist and other trained members of staff.

Members of the pharmacy team working on the medicines counter used appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist for further advice on how to deal with a transaction. Team members undertook both online and face-to-face training on new products, clinical topics, operational procedures and services. They had recently completed a training module on customer care. The ACT received quarterly performance and development reviews which included both personal and company objectives. Other team members received ad hoc feedback about their performance and had a scheduled conversation with their line manager at the beginning of each year. They could discuss issues with the pharmacists or management team informally whenever the need arose. The lack of a structured performance and development programme for non-registrant team members increased the risk that opportunities to identify training needs could be missed.

There were no specific targets or incentives set for the services provided. The pharmacy team worked very well together in a supportive environment and the atmosphere in the pharmacy was calm and professional. Members of the team 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 management team or area manager. The company’s whistleblowing policy was available in both the staff area and the dispensary. It was also available on the pharmacy’s intranet system. The policy included a confidential helpline for reporting concerns outside the organisation.

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 and tidy. The dispensary was small but well-organised, with enough space for safe working. The pharmacy team provided some services via a secure hatch at the store entrance. The sink had hot and cold running water and soap and cleaning materials were available. A cleaner attended daily during working hours. Hand sanitiser was available for staff use. 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 effectively 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 which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. The pharmacy team signposted people requesting services they could not provide to other nearby pharmacies. Some health promotional material was available in the retail area. One of the regular pharmacists had recently visited a local optician to discuss and promote the common ailments service as part of a health board funded collaborative working initiative.

The pharmacy was open for longer hours than the store. An intercom at the store entrance connected to a telephone line in the dispensary. This allowed people to speak to a member of the pharmacy team when the store was closed. The pharmacist could then conduct any necessary consultations or transactions via the pharmacy hatch at the store entrance.

About 60% of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines or most controlled drugs or and these continued to be dispensed at the branch. Dispensing staff used a colour-coded basket system to help 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 messaging service was available to let people know their medicines were ready for collection.

Patient information forms (PIFs) were added to prescriptions to highlight any issues that needed to be brought to the pharmacist's attention before checking, or at the point of handout, such as counselling opportunities. Coloured cards were attached to prescriptions to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Cards were also used to identify patients prescribed paediatric medicines for counselling. Stickers marked with an expiry date were attached to prescriptions for schedule 3 and 4 CDs. This was to help ensure that the medicines would only be supplied if the prescription was still valid.

Coloured cards were attached to prescriptions for high-risk medicines such as warfarin, lithium, methotrexate and valproate to identify the patient for counselling. The cards included prompt questions to ensure that the member of staff handing out the prescriptions obtained all necessary information from the recipient. Team members explained that this information was usually added to the patient medication record (PMR). They were able to produce an example of a recorded INR result, although this was not recent. The pharmacy team were aware of the risks of valproate use during

pregnancy. They were also aware of the requirement to provide all valproate products in original packs wherever possible. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but a member of staff said that any such people would be counselled and provided with information at each time of dispensing.

The pharmacy offered a wide range of services. Demand for the emergency supply of prescribed medicines service was high, as the pharmacy was open for longer hours than local GP surgeries and most other pharmacies. The branch manager explained that there had recently been an increase in uptake of the emergency supply service on Saturdays, as many local pharmacies were now closed at weekends. There was a high uptake of the common ailments service. Uptake of the discharge medicines review service was low. The pharmacy provided a seasonal influenza vaccination service for NHS and private patients. People could book appointments online and clinics were held for two hours each morning and afternoon. The pharmacy team aimed to provide twenty-one influenza vaccinations each day. Walk-in appointments were sometimes provided if the pharmacy team had the capacity to offer these. The pharmacy provided a prescription collection service from five local surgeries. It did not routinely offer a prescription delivery service. However, the branch manager explained that the Boots delivery hub or a local taxi service could deliver medicines in the event of an emergency.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, it was clear that the dispensary stock storage area was full to capacity. Different products and different strengths of the same product were stored closely together, which might increase the risk of selection errors. Medicines requiring cold storage were kept in one of two well-organised drug fridges. 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. Some dispensed CD prescriptions awaiting collection that were being stored in the CD cabinet were no longer valid, as more than 28 days had elapsed since the date on the prescription. The branch manager said that this was an oversight and gave assurances that they would be dealt with appropriately.

Stock was subject to regular documented expiry date checks. Date-expired medicines were disposed of appropriately, as were waste sharps and patient returns. The pharmacy received drug alerts and recalls via its NHS email account which was checked at the beginning and end of each day. A member of staff was able to describe how the team would deal appropriately with medicines or medical devices that had been recalled as unfit for purpose. This included contacting patients where necessary and returning quarantined stock to the relevant supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services. And it makes sure these are always safe and suitable for use.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. Triangles and capsule counters were used to count loose tablets and capsules. Separate triangles were 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 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.

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.