General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Aberafan Centre, PORT TALBOT, West Glamorgan, SA13 1PB

Pharmacy reference: 1043800

Type of pharmacy: Community

Date of inspection: 31/10/2019

Pharmacy context

This is a shopping centre pharmacy in a small town. 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

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	Members of the pharmacy team review and analyse Iinformation about risk to help them 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 role and are supported to address their learning and development needs.
		2.4	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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
		4.2	Good practice	The pharmacy has robust systems in place to ensure that patients prescribed high-risk medicines are appropriately counselled. Its procedures for supplying medicines in compliance aids are well-managed.
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

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. A list of daily and weekly tasks to be undertaken by staff were displayed in the pharmacy for reference. The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. Action had been taken to reduce some risks that had been identified: for instance, after a series of quantity errors, staff had begun to circle the quantity when dispensing each item to show that it had been double-checked. Following a direction from the superintendent's office, extra safety measures had been put in place for 'Look-alike, Sound-alike' or 'LASA' drugs that were commonly the subject of patient safety incidents. A list of these drugs was displayed at each labelling terminal for reference. Pre-printed caution stickers had been used to help reduce the risk of incorrect selection and staff also marked prescriptions for LASA drugs to further alert staff to the risk of errors. The pharmacy team said that errors had reduced dramatically since the introduction of the new Columbus pharmacy software programme, which 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 dispensing label. 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 read and signed. The most recent bulletin was displayed on the pharmacy noticeboard for reference. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

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. Leaflets 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 current 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, emergency supply records were not always made in line with legal requirements, as some did not include the nature of the emergency. There was a risk that there might not be enough information available to allow the pharmacy team to fully resolve queries or deal with errors effectively. CD running balances were typically checked weekly and at the time of dispensing.

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. Individual staff members had unique passwords to access the pharmacy computer that the system prompted them to change at regular intervals. A notice at the medicines counter described the way in which data was processed and used by the pharmacy.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Staff had undertaken level one safeguarding training and were able to identify different types of safeguarding concerns. A summary of the company's chaperone policy was advertised in a poster displayed on the consultation room door and near the medicines counter. Leaflets which included advice on how to support people with dementia were displayed in the retail area.

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

The regular pharmacist worked on most days except Sundays and his absences were covered by relief pharmacists. A regular relief pharmacist also covered his lunch hour between 1pm and 2pm. He was assisted in the day-to-day operation of the pharmacy by the branch manager, who was a qualified dispensing assistant. The support team consisted of a trainee pharmacy technician, a dispensing assistant, two medicines counter assistants and a retail assistant. Two other dispensing assistants were absent. The pharmacy manager said that the retail assistant did not work in the dispensary or on the medicines counter and always referred any requests for medicines or advice to trained members of staff.

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 trainee pharmacy technician worked under the supervision of the pharmacist. Targets were set for MURs but these were managed appropriately and the pharmacist said that they did not affect his 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 pharmacists or store manager. Information on how to report concerns via a confidential helpline was available in a signposting folder in the dispensary.

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 members undertook online training on new products, clinical topics, operational procedures and services. They completed regular paper-based assessments to reinforce this training and recent assessment topics had included high-risk medicines and paediatric medicines. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacists or pharmacy 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 clean, tidy and well-organised, with enough space to allow safe working. Some stock was being temporarily stored on the floor, but it did not pose a trip hazard. 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. 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 he 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 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 is well-organised and its working practices are safe and effective. It supports people taking higher-risk medicines by making extra checks and providing counselling where necessary. It 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 offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. A signposting file provided by the local health board was available and staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. A list of local sexual health clinics was available in the consultation room. Some health promotional material was on display in the retail area. A machine in the retail area measured customers' weight, height, BMI and body fat for a small charge. The pharmacist said that he had recently visited local surgeries and a nearby optician to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the Choose Pharmacy common ailments service.

Dispensing staff used a basket system to help ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. 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.

Patient information forms (PIFs) were added to each prescription to highlight any issues that needed to be brought to the pharmacist's attention, such as patient eligibility for an MUR or counselling opportunities. 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. Coloured cards were used to flag up prescriptions for high-risk drugs such as warfarin, methotrexate and lithium. They included prompt questions to ensure that the member of staff handing out the prescriptions obtained all necessary information from the recipient, which was then added to the patient medication record (PMR). Cards were also attached to prescriptions to highlight the fact that a CD or fridge line needed to be added before the prescription was handed out.

The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. A valproate patient information pack was available in the dispensary. A poster detailing current guidance and safety information for patients prescribed valproate was displayed on the dispensary noticeboard. Steroid cards and warfarin and lithium monitoring booklets were also available for provision to patients. 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.

A text messaging service was available to let patients know their medicines were ready for collection. Prescriptions awaiting collection were marked with five different coloured stickers that corresponded to different weeks. They remained on the shelf for five weeks before the patient was contacted and the medicines were returned to stock after a few more days if not required.

The pharmacy provided a delivery service for a charge. This 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. Staff 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 number of patients. These medicines were assembled in a well-organised dispensary on the first floor. Trays were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. A dedicated communications book for compliance aid patients was used to record messages and queries. A progress log for all patients was displayed and showed the status of each patient's tray at any given time. Each entry in the log was initialled and dated to provide an audit trail. Each patient had a section in one of four dedicated files that included their personal and medication details, collection or delivery arrangements, details of any messages or queries and relevant documentation, such as current prescriptions and repeat order forms. Flags were added if a patient was prescribed high-risk medicines or 'LASA' medicines. 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 a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in a well-organised CD cabinet and obsolete CDs were segregated from usable stock.

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 which was checked at the beginning and end of each day. Staff were able to describe how they had dealt with a recent drug recall for Zantac 75mg tablets by quarantining affected stock and returning it to the relevant supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary equipment to work in accordance with the Falsified Medicines Directive, but the team were not currently decommissioning medicines. The pharmacist said that there was a plan to begin doing so within the next few weeks.

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 capsule counters were used to count tablets and capsules. Staff said that these were washed after 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. 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.