General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 51 Uplands Crescent, SWANSEA, West Glamorgan, SA2 0NP

Pharmacy reference: 1043902

Type of pharmacy: Community

Date of inspection: 06/11/2023

Pharmacy context

This is a neighbourhood pharmacy in a busy student area. 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	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	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. Pharmacy team members understand 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 pharmacist 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. Some quantity errors still occurred. As a result, pharmacy team members 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. The pharmacist explained that further analysis had revealed that these errors typically occurred during very busy periods. The team had consequently begun to review their time management procedures to help them reduce the risk of errors. They had taken the decision to close for an hour at lunchtime each day, allowing them to manage staffing levels more effectively and to catch up on workload without interruptions. 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 paper and electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team had read and signed the SOPs, completing an online declaration and assessment for each electronic SOP. The responsible pharmacist notice displayed was incorrect and the pharmacist remedied this as soon as it was pointed out to him.

A notice displayed at the medicines counter encouraged customers to complete an online survey about customer care. Results of these surveys were sent directly to the pharmacist manager. 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. Leaflets advertising the NHS 'Putting Things Right' complaints procedure were also displayed.

Evidence of current professional indemnity insurance was available. All necessary records were kept, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. Most records were properly maintained, although the RP register had not

been completed on 11 October 2023 and there were occasions on which the pharmacist had not signed out of the register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. CD running balances were checked at the time of dispensing and a stock check of the entire cabinet was carried out either weekly or fortnightly.

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 notice displayed near the medicines counter provided information on the way in which personal data was used and managed by the pharmacy, including how to raise a complaint with the information commissioner's office. All members of the pharmacy team had undertaken formal safeguarding training and had access to safeguarding guidance and local safeguarding contact details that were available in the dispensary. A poster advertising the 'Safe Spaces' domestic abuse service was displayed inside the consultation room and included details of helplines and support groups.

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

The regular pharmacist manager usually worked at the pharmacy and was assisted by a second pharmacist on one or two days each week. The support team consisted of a pharmacy technician, three dispensing assistants (DAs), a trainee DA and a pharmacy student who worked on Saturdays. The pharmacy was also currently providing a four-month training placement for a full-time foundation pharmacist. The pharmacy was busy, but there were enough suitably qualified and skilled team members present to manage the workload during the inspection and the staffing level appeared adequate for the services provided. The foundation pharmacist, 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 online training on new products, clinical topics, operational procedures and services. The pharmacy technician received bi-annual 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 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.

Targets were set for some of the services provided, but these were managed appropriately, and the pharmacists said that they did not affect their professional judgement or compromise patient care. The pharmacy team worked well together in a supportive environment. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists or area manager. The company’s whistleblowing policy was advertised in the staff area and was also available on the pharmacy’s intranet system. It 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 generally clean and tidy. The dispensary was small but well-organised, with enough space for safe working. Some dispensary stock was being temporarily stored on the floor, but this did not create a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. The pharmacy team explained that the dispensary sink was not working properly, as although it could be used, the plumbing system was not able to deal with large volumes of waste water. A maintenance team were in the process of fixing the problem. The pharmacy team were consequently limiting the use of the sink to the reconstitution of medicines until the problem was resolved. The bathroom and kitchen sinks were being used for all other cleaning and hygiene purposes. Hand sanitiser was available in the dispensary for staff use. Plastic screens had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers. 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'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. 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, and a hearing aid loop was available. The pharmacy team signposted people requesting services they could not provide to nearby pharmacies or other agencies such as a community needle exchange service. A signposting file provided by the local health board was available in the dispensary and a poster listing details of local sexual health services was displayed in the consultation room.

Most of the pharmacy's dispensing workload consisted of walk-in prescriptions. Dispensing staff used a 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. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know their medicines were ready for collection.

Prescriptions awaiting collection were marked with one of four different coloured stickers that corresponded to specific weeks. They remained in the collection area for four weeks before the patient was contacted as a reminder to collect. Another reminder was sent a week later, and the medicines were then returned to stock if not collected or required. Corresponding prescriptions were stored until they were no longer valid, then shredded. The system ensured that there was always enough storage space for current prescriptions.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When staff needed to locate a prescription, the patient's name was typed into a handheld device and this brought up a list of locations in which their items were being stored, including the drug fridge or CD cabinet where applicable. 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. 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). 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 the pharmacist said that any such people would be counselled and provided with information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of people. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. 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 changes and any relevant documentation, such as current prescriptions and discharge letters. A note was added if the person was known to be in hospital. Some individual sheets listing medication details were untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which might increase the risk of errors. A progress log for each patient was available and showed the status of each person's tray at any given time.

The pharmacy offered a wide range of services. Demand for the emergency supply of prescribed medicines service and the EHC service was high, as the pharmacy was situated in a busy student area and was open until 5.30pm on Saturdays, unlike many other local pharmacies. There was a steady uptake of the common ailments service, with some referrals from local GP surgeries. The pharmacy provided a seasonal influenza vaccination service for NHS and private patients. People could book appointments online. The pharmacy team aimed to provide twelve influenza vaccinations each weekday and four vaccinations on Saturdays. Walk-in appointments were sometimes provided if the pharmacy team had the capacity to offer these.

The pharmacy provided a prescription collection service from ten local surgeries. It offered a prescription delivery service that was managed by the Boots delivery hub. Patients or their representatives signed a handheld electronic device to acknowledge receipt of delivery as an audit trail. The delivery list was marked to show if a controlled drug had been included. This allowed the delivery driver to notify the patient that they were receiving a CD. The pharmacist said that patients due to receive a delivery were telephoned beforehand by the hub 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, or occasionally to the drivers' hub branch in Neath. Any prescriptions left at the hub branch were returned to the pharmacy the next day, or the next Monday if the failed delivery was on a Friday.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some dispensary stock storage areas were untidy, including the drug fridge and some sections of the CD cabinet. Different products and different strengths of the same product were stored closely together, which might increase the risk of selection errors. One dispensed CD prescription awaiting collection that was being stored in the CD cabinet was no longer valid, as more than 28 days had elapsed since the date on the prescription. The pharmacist said that this was an oversight and gave assurances that it would be dealt with appropriately. He carried out a balance check of the CD cabinet during the inspection and took the opportunity to reorganise and tidy the stock. Each substance misuse client was allocated a separate section in the CD cabinet for their dispensed doses plus any relevant documents such as their current prescription, supervision record form and any written communication from the prescribing service. Maximum and minimum temperatures for the drug fridge were usually recorded daily, although there were occasional gaps in the records. Recorded temperatures were consistently

within the required range.

Stock was subject to regular documented expiry date checks, although the team had fallen behind with these over the last few weeks. However, no out-of-date medicines were found. Stickers were used to highlight short-dated stock and pharmacy team members explained that they included a date check as part of their dispensing and checking procedures. Date-expired medicines were disposed of appropriately, as were waste sharps and patient returns. A clinical waste bin was also available in the consultation room. The pharmacy received drug alerts and recalls via Boots internal emails and its NHS email account, which was checked at the beginning and end of each day. The pharmacist manager received MHRA alerts via his personal mobile phone. He 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 a capsule counter were used to count loose tablets and capsules. A separate triangle was 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.