General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Unit 1 & 2, Broadcasting House, Central Square, Cardiff, Caerdydd, CF10 1FS

Pharmacy reference: 9011031

Type of pharmacy: Community

Date of inspection: 10/07/2019

Pharmacy context

This is a newly-built pharmacy in the centre of a capital city. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers services including emergency hormonal contraception, treatment for minor ailments, private pneumonia vaccination and a seasonal flu vaccination service for NHS and private patients. It also provides substance misuse services to a large number of clients.

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	Good practice	2.1	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.
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 the same sorts of 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. The pharmacist said that errors had reduced dramatically since the introduction of the new Columbus pharmacy software programme, which allowed many prescription items to be scanned so that the drug field in the patient medication record could be populated directly from the barcode. 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. Lists of 'look alike, sound alike' or 'LASA' drugs that were repeatedly the subject of patient safety incidents throughout the company were displayed at each computer terminal. Prescriptions for these drugs were marked to alert staff to the increased risk of errors. After a series of near misses involving incorrect quantities staff now wrote and circled the quantity on split boxes to help avoid errors occurring. The risks associated with the influenza vaccination service had been assessed and a poster describing the process to follow in the event of a needlestick injury was displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided; these were regularly reviewed. A new member of staff was in the process of reading and signing SOPs relevant to his role. Two medicines counter assistants (MCAs) had not signed to show they had read and accepted the procedures relating to the responsible pharmacist regulations and an appendix of the 'staff roles and responsibilities' SOP showing the tasks that each staff member was expected to perform had not been completed. However, the MCA present was observed to follow SOPs relevant to her role and could describe her responsibilities. She understood which activities could and could not take place in the absence of the RP.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed in the retail area showed that this was mostly positive. 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. A poster and leaflets advertising the NHS complaints procedure 'Putting Things Right' were also displayed in the retail area.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, 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 checked weekly or more frequently.

Staff received annual training on the information governance policy and had signed confidentiality agreements as part of this training. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately.

The pharmacist and staff had undertaken formal safeguarding training and had access to guidance and local contact details that were filed in the dispensary. A summary of the chaperone policy was advertised in a poster displayed inside the consultation room. Leaflets with information about living with dementia and children's mental well-being were displayed at the medicines counter.

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

Inspector's evidence

The regular pharmacist manager oversaw all professional activities on three days each week. His absences were covered by relief pharmacists employed by the company. 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. A dispensing assistant and a pharmacy technician had left the company during the previous month and their roles were being covered by a relief accuracy checking technician (ACT) and a newly-appointed pharmacy technician who was absent on the day of the inspection. The pharmacist said that the company was currently recruiting to replace the dispensing assistant but had had no success as yet.

Most staff members had the necessary training and qualifications for their roles. A member of staff who had been employed for nearly three months had not received any formal training. However, he had completed an in-house induction course and referred all requests for advice or medicines to the pharmacist or another trained member of staff. The store manager said that he was to be enrolled on a formal training course shortly.

Targets were set for MURs but these were managed appropriately. The pharmacist said that there was some pressure to complete MURs but this did not affect his professional judgement or patient care. Staff worked well together and 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 pharmacist or store manager. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

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 provided by the organisation on new products, clinical topics, operational procedures and services. The ACT understood the revalidation process. He said he had recently submitted his continuing professional development (CPD) portfolio and based his entries on training provided by the company. All staff were subject to regular performance and development reviews and 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 protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow safe working, although some stock was temporarily stored on the floor. The sinks had hot and cold running water and soap and cleaning materials were available.

A lockable consultation room was available for private consultations and counselling and its availability was clearly advertised. A semi-private screened hatch that opened into the dispensary from a quiet part of the retail area was used by substance misuse and needle exchange clients. No confidential information was visible from 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 generally safe and effective. Its substance misuse services are particularly well-managed. And it generally manages medicines well.

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. During the inspection a member of staff signposted a patient requesting a service they could not provide to another local pharmacy. Some health promotional material was on display in the retail area. A machine in the retail area measured customers' weight, height and BMI for a small charge. The pharmacist had recently visited local surgeries and a nearby community addiction unit to discuss and promote services as part of a health board-funded collaborative working initiative. Recent visits had involved discussions around the influenza vaccination service, the repeat dispensing service and the common ailments service.

The pharmacist said that the workload was easy to manage as most of it consisted of repeat prescriptions with occasional walk-ins. A dispensary communications book was used to ensure continuity of service. Dispensing staff used a 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 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.

Pharmacist 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. Stickers were generally 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. However, a prescription for diazepam and one for zopiclone were not marked in this way. Coloured cards were attached to prescriptions to highlight the fact that a CD requiring safe custody or a fridge line needed to be added before the prescription was handed out, or that the pharmacist wished to speak to the patient or their representative at the point of handout.

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. Staff said that coloured cards were used to flag up prescriptions for high-risk drugs such as warfarin, lithium, methotrexate and valproate, although no evidence was available. The pharmacist demonstrated that the cards included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information from the recipient. Some INR results for patients prescribed warfarin had been entered on the patient medication record (PMR). 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 appropriately and provided with

relevant information. He demonstrated that patient information was stored with stocks of valproate in the dispensary. A poster detailing NICE guidance and safety advice for supplying valproate was displayed in the dispensary.

Patients were sent text messages to let them know that their medicines were ready for collection. One patient came into the pharmacy during the inspection and said that he had been waiting for a text message but had not received one and needed to collect his medication as he had run out. His prescription was ready to be collected and the pharmacist apologised. He said that he would send a test message to him later that afternoon to check that there were no problems with the system. Prescriptions awaiting collection were marked with coloured stickers that corresponded to specific weeks of the month. They remained on the shelf for four to five weeks before the patient was contacted and the medicines returned to stock after a further three to four weeks if not collected.

The pharmacy delivered prescriptions to about 10 patients each week. The service was managed electronically: patients or their representatives signed a handheld electronic device to acknowledge receipt of delivery as an audit trail. The pharmacist said that separate signatures on paper forms would be obtained for deliveries of controlled drugs, although there had been no controlled drug deliveries since the pharmacy had opened in 2018. The pharmacist said that in the event of a missed delivery, the delivery driver put a notification card though the door and usually brought the prescription back to the pharmacy. However, he said that undelivered prescriptions would sometimes be taken to the Llanishen or Queen Street branch for overnight storage, except for compliance aids and items that patients required urgently. It was unclear if patients had given consent for their prescription to be sent to another branch in these circumstances and there was a risk that this practice might compromise confidentiality.

The pharmacy had a high number of substance misuse clients and managed them well. The pharmacy dealt with prescriptions from several local agencies and GP surgeries and the pharmacist said that the team were in continued contact with these organisations to ensure a high standard of care. Medication for each client was prepared in advance and stored in the relevant labelled section of a dedicated CD cabinet. Clients of the supervised consumption service were routinely offered water with their dose. A notice at the hatch reminded clients that on Sundays the supervised consumption service was only available between 11am and 3pm. The pharmacist said that there was a high uptake of the needle exchange service, with about 20 clients using the service each day.

Disposable compliance aids were used to supply medicines to a number of patients. A communications book was used to record all telephone calls, enabling messages and queries to be dealt with efficiently. Compliance aids were labelled with descriptions, although these needed more detail to enable identification of individual medicines, as many simply stated ‘round white tablet’. 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 and details of any messages or queries.

Medicines were obtained from licensed wholesalers and stored appropriately, including those requiring cold storage. CDs were stored appropriately in very tidy, well-organised CD cabinets. The pharmacist said that the number of substance misuse clients had been taken into consideration when fitting the pharmacy’s CD cabinets following the recent relocation. 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 which was checked at the beginning and end of each day. The pharmacist was able to describe how he would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive (FMD) but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide 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 CDs and most daily liquid CD doses were measured using a Varispense Plus pump. The pharmacist said that the pump was calibrated before use and cleaned after each measuring session, although no records were made. Triangles and a capsule counter were used to count tablets and capsules. Staff said that these were always 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. There was no evidence that it had recently been tested but the store manager said that all equipment had been newly purchased for the relocation in October 2018 and would be tested annually. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the computer was password-protected 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.