General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 20-30 Obelisk Way, CAMBERLEY, Surrey, GU15 3SD

Pharmacy reference: 1036418

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

A busy community pharmacy set in a shopping centre in Camberley. The pharmacy opens seven days a week. It sells a range of over-the-counter (OTC) medicines and health and beauty products. It dispenses NHS and private prescriptions. It supplies medicines to several care homes and provides multi-compartment compliance packs (compliance packs) to help people take their medicines. It delivers medicines to people who can't attend its premises in person. The pharmacy provides travel vaccinations and anti-malarial medicines. It also provides seasonal influenza (flu) and pneumonia vaccinations. And it offers other vaccinations, including for chickenpox, meningitis B and human papilloma virus (HPV). The pharmacy can supply the morning after pill for free. And it can provide free chlamydia testing kits and treatments to certain people. It also offers a stop smoking service, NHS health checks and a substance misuse treatment service.

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	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
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 makes sure that its services are accessible and meet the needs of the people it serves.
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 its team works safely. It continually monitors the safety of its services to protect people and further improve patient safety. Its team members log and review the mistakes they make. So, they can learn from these and act to avoid problems being repeated. The pharmacy has appropriate insurance to protect people if things do go wrong. It mostly keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They understand their role in protecting vulnerable people. And they generally keep people's private information safe.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. The pharmacy had separate rooms for the assembly of medicines for care homes and people's compliance packs. But the rooms were in different parts of the building to the main pharmacy. And they were small. So, the team members responsible for making up people's prescriptions tried to keep the workstations in each room and the main pharmacy tidy. The pharmacy kept an audit trail on each prescription for each stage of the dispensing process from clinical screening by a pharmacist through to the handing out of the assembled prescription. Members of the pharmacy team used plastic containers to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by an appropriately trained checker who also initialled the dispensing label. The pharmacy had robust systems to record and comprehensively review dispensing errors, near misses and other patient safety incidents. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes regularly to help spot the cause of them and any trends. So, they could try to stop them happening again and improve the safety of the dispensing service they provide. They highlighted look-alike and sound-alike drugs in each dispensary to reduce the risk of them picking the wrong product. And they've recently reviewed and strengthened their controlled drug (CD) dispensing process following a supply of the wrong strength of a CD to a patient. The safety and quality of the pharmacy's services were also monitored and reviewed periodically during company compliance audits. So, the pharmacy team could make further improvements to make sure it provided safe and effective care.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. Its team members were required to wear name badges which identified their roles within the pharmacy. And their roles and responsibilities were described within the SOPs. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to a pharmacist. A complaints procedure was in place and patient satisfaction surveys were undertaken annually. The results of last year's patient satisfaction survey were available online. The pharmacy's practice leaflet told people how they could provide feedback about the pharmacy in person, online or by contacting the

company's customer care centre. The pharmacy team asked people for their views. People's feedback led to the pharmacy reviewing its staffing levels over the lunch period when it was particularly busy.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The address from whom a CD was received from wasn't always recorded in the pharmacy's CD register. A few entries in the CD register were crossed out. And sometimes correctional notes in it were undated. But its running balance was checked regularly as required by the SOPs. The pharmacy's RP records were generally kept in order. But a pharmacist recently forgot to record when they were absent from the pharmacy. The nature of the emergency within the records for emergency supplies made at the request of patients sometimes didn't provide enough detail for why a supply was made. The prescriber's details and date of prescribing were occasionally incorrectly recorded in the pharmacy's private prescription records. The date an unlicensed medicinal product was obtained wasn't routinely included in the pharmacy's 'specials' records.

An information governance (IG) policy was in place. And members of the pharmacy team were required to complete online IG training. The pharmacy displayed a notice that told people how it, and its team, gathered, used and shared their personal information. It had arrangements to make sure confidential waste was collected and destroyed securely. But people's details weren't always removed or obliterated before patient-returned waste was disposed of. A safeguarding policy and a list of key contacts for safeguarding concerns were available. Members of the pharmacy team were required to complete safeguarding training relevant to their roles. And they could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough team members to deliver safe and effective care. Members of the pharmacy team are trained for the jobs they do. And they keep their skills and knowledge up to date. They use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 63 hours a week. It dispensed about 13,000 NHS prescription items a month. The pharmacy team included two part-time pharmacists, a full-time pre-registration pharmacist trainee, a full-time accuracy checking pharmacy technician (ACPT), two part-time pharmacy technicians, five full-time dispensing assistants, seven part-time dispensing assistants, two full-time trainee dispensing assistants and a full-time pharmacy apprentice. There were vacancies for two pharmacists, an ACPT and two dispensing assistants at the time of the inspection. The pharmacy's ACPT has been away from work for some time. So, the pharmacy relied upon its team, relief staff or staff from a nearby branch and locum pharmacists to cover vacancies and absences. And to provide additional support when the pharmacy was busy. The store manager was also a trained dispensing assistant. So, he could help the pharmacy team when needed. One of the pharmacy's regular pharmacists, two locum pharmacists, the pre-registration pharmacist trainee, a pharmacy technician, five dispensing assistants and the store manager were working at the time of the inspection.

The pharmacy's team members needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period and an induction training programme. They worked well together and supported each other. So, prescriptions were processed efficiently, but safely, and people were served promptly. The pharmacists supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team followed. A member of staff described the questions he would ask when making over-the-counter recommendations and when he would refer people to a pharmacist. For example, requests for treatments for animals, infants or children, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions.

Members of the pharmacy team discussed their performance and development needs throughout the year with their line manager and at colleague reviews. They were encouraged to ask questions and familiarise themselves with new products. They were also encouraged to read company newsletters and complete training and assessments to make sure their knowledge was up to date. And they could train while they were at work. But they were sometimes too busy dealing with people or helping manage the pharmacy's workload to do all the training they needed to. Team meetings and one-to-one discussions were held to update staff and share learning from mistakes or concerns. The pharmacy had a whistleblowing policy in place. Its team felt comfortable about making suggestions on how to improve the pharmacy and its services. Staff knew how to raise a concern if they had one. And their feedback identified a need for more appropriately trained team members to be available to work at the pharmacy counter during busy periods. Members of the pharmacy sometimes found it challenging to do all the things they were expected to do. But they didn't feel their professional judgement or patient

safety were affected by targets. And, for example, Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has a room where people can have private conversations with members of the pharmacy team. And it provides an adequate and secure environment for people to receive healthcare. But it had limited space for its team to work in.

Inspector's evidence

The premises were only partially registered with the GPhC at the time of the inspection. And registrable activities were undertaken within separate and distinctly different parts of the building. But the company asked the GPhC to register the entire premises shortly after the inspection. The main pharmacy was located on the ground floor of the building. And it included a pharmacy counter, a consultation room and a dispensary. It was air-conditioned, bright, clean, secure and adequately presented. But it had limited space for the pharmacy team to work in. The care home dispensary and associated rooms were located on the first floor of the building. And these too had limited space for the pharmacy team to work in. People's compliance packs were assembled in a room also located on the first floor due to the limited space in the main pharmacy. The fixtures and fittings throughout the pharmacy were dated and worn. And some areas of flooring had started to lift. The consultation room was of an adequate size. It was used mainly for MURs, NMS consultations, the pharmacy's vaccination services and if people needed to speak to a team member in private. It had a small table, some storage, a sink and seating. It was locked when not in use to make sure its contents were kept secure. The pharmacy was cleaned regularly by a cleaning contractor. And the pharmacy team also tried to keep the premises clean and tidy. The pharmacy's sinks were clean. And the pharmacy had a supply of hot and cold water. It also had appropriate handwashing facilities for its staff.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes sure that its services are accessible and meet the needs of the people it serves. The pharmacy's working practices are generally safe and effective. It offers vaccinations and keeps records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources and it stores most of them appropriately and securely. Members of the pharmacy team are helpful. And they make sure people have the information they need to take their medicines safely. They generally dispose of people's waste medicines properly. They mostly carry out the checks they need to. And they respond well to drug alerts or product recalls. So, people get medicines or devices which are safe.

Inspector's evidence

The store and the main pharmacy were located on the ground floor of a shopping centre. The store's entrance was level with the shopping centre's flooring. The aisles leading to the pharmacy were kept clear. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy and its services. The pharmacy's services were advertised in-store and were included in its practice leaflet. Team members knew where to signpost people to if a service wasn't provided. And they were helpful and provided advice to people on how to take their medicines safely. The pharmacy provided an extensive range of services tailored to the needs of the local population. For example, its vaccination services, compliance pack dispensing and delivery service. The pharmacy team worked closely with other providers to identify people who would benefit from these services.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines. The pharmacy stop smoking service was only available one day a week when a suitably trained team member was working. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be repackaged. And it had a process to assess if a person was eligible for the service. The pharmacy team provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were routinely supplied. The care home dispensing service had established procedures in place. The pharmacy team liaised with the care homes about issues that may affect the care of their residents. And it kept records of these communications; for example, missing items and changes to people's medicines. The pharmacy had valid and up-to-date patient group directions (PGDs) for the morning-after pill, chlamydia treatments, hair-retention medication, anti-malarial medicines and flu, pneumonia, chickenpox, HPV and meningitis B vaccinations. The pharmacy team knew how to handle requests for these services. It used an online diary to plan when travel clinic consultations and vaccinations could be done. And if the pharmacy didn't have a suitably qualified pharmacist available or if it was particularly busy then its team could close the diary to prevent appointments being made at these times. One of the pharmacy's regular pharmacists was suitably trained to provide all the PGDs. So, the PGD services weren't available every day the pharmacy was open. The pharmacy team promoted the benefits of its flu vaccination service to at-risk groups, care homes, staff of neighbouring businesses and other people attending its premises. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. The pharmacy had appropriate anaphylaxis resources in place for its vaccination services. It kept a record for each vaccination it made.

And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacist got another appropriately trained team member to check that the vaccine they selected was the correct one before administering it. The pharmacy team made sure the sharps bin was kept securely when not in use. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. A 'Counselling Reminder' card and a 'Pharmacist Information Form' were used to alert the person handing the medication over that these items had to be added or if extra counselling was required. Prescriptions for CDs were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. But some medicines were found within inadequately labelled containers. And a few split packs were found to contain stock from different batches. So, the pharmacy team promptly quarantined these medicines to make sure they weren't supplied. Pharmaceutical stock was subject to date checks, which were documented, and short-dated products were marked. The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock at the time of the inspection. The pharmacy team was uncertain as to when the pharmacy would become FMD compliant. Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had suitable waste receptacles for the disposal of hazardous and non-hazardous waste. But some cytostatic waste was found in a pharmaceutical waste bin intended for non-hazardous waste. The pharmacy team had also allowed pharmaceutical waste, mainly from its care homes, to build up. So, it needed to arrange for this waste to be promptly collected and destroyed by an appropriate waste contractor. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And staff described the actions they would take and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And staff made sure the equipment they used to measure or count medicines was clean before using it. The pharmacy team had access to up-to-date reference sources. And it could contact the Chief Pharmacist's office to ask for information and guidance. The pharmacy had suspended its NHS health check service as the diagnostic equipment it used to deliver the service had developed a fault. The pharmacy had three medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. Access to the pharmacy's computers and the patient medication record system was restricted to authorised team members and password protected. The computer screens were positioned so only staff could see them. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.

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.