General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 34 Church Walk, CATERHAM, Surrey, CR3 6RT

Pharmacy reference: 1036476

Type of pharmacy: Community

Date of inspection: 15/12/2022

Pharmacy context

This is an NHS community pharmacy set in a shopping centre in Caterham. The pharmacy is part of a large chain of pharmacies. It opens seven days a week. It sells over-the-counter medicines. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy provides a substance misuse treatment service. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get their flu vaccination (jab) at the pharmacy too.

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 appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy review the mistakes they make and learn from them to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, as a result, it put some plastic screens on its counters to try and stop the spread of the virus. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to say they understood them and would follow them. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team had separated some higher-risk medicines, such as methotrexate, sulfonylureas and quetiapine, from other stock to help reduce the risks of the wrong product being picked. They discussed, documented and reviewed the mistakes they made to learn from them and reduce the chances of them happening again. And, for example, they strengthened their dispensing procedures to make sure people got the right number of tablets.

The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they couldn'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, such as medicines liable to abuse, misuse or overuse, to a pharmacist. People could share their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had leaflets which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were checked as often as the SOPs asked them to be. But the details of where a CD came from weren't always completed in full. The pharmacy kept appropriate records to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incorrect in the private prescription records. The pharmacy kept a record for the supplies of the unlicensed medicinal products it made. But its team sometimes forgot to record when it had received an unlicensed medicinal product.

People using the pharmacy couldn’t see other people’s personal information. The company that owned the pharmacy was registered with the Information Commissioner’s Office. The pharmacy had policies on information governance and safeguarding. It displayed a notice that told people how it gathered, used and shared their personal information. And it had arrangements to make sure confidential information was stored and disposed of securely. Members of the pharmacy team were required to complete training on information governance and safeguarding. They knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. They were aware of the ‘Ask for Ani’ campaign. They could help people get the support they needed if they were asked. And the RP had completed level 3 safeguarding training too.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough people in its team to deliver safe and effective care. But team members are sometimes so busy they struggle to do all the things they are asked to do. Members of the pharmacy team do the right training for their roles. They work well together and 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. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist store manager (the RP), a part-time pharmacist, two part-time trained pharmacy advisors, a part-time trainee pharmacy advisor, a part-time trained medicines counter assistant (MCA), a part-time trainee MCA and a temporary part-time store colleague. The part-time store colleague didn't work in the healthcare area of the pharmacy. The RP, a pharmacy advisor, the trainee pharmacy advisor and the MCA were working at the time of the inspection. The pharmacy relied upon its team, locum pharmacists and team members from other nearby branches to cover absences or provide additional support when the pharmacy was busy. But it occasionally struggled to cover absences. Members of the pharmacy team were sometimes under pressure to do all the things they were asked or expected to do as they didn't always have enough time to do them. And they were a day or so behind with their workload. But they didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. And they worked well together and helped each other to serve people and dispense prescriptions safely. The RP led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. And they explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist. People working at the pharmacy needed to complete mandatory training during their employment. They were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were usually kept up to date during one-to-one discussions or ad hoc meetings. And they were encouraged to complete training when they could. But they generally trained in their own time as they were often too busy to train when they were at work. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to a regular pharmacist store manager being employed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright, clean, secure and appropriately presented. But its dispensary had limited workbench and storage space available. And its worksurfaces could become cluttered and bulky items were often stored on the floor when it was busy. The pharmacy had a consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy used a cleaning company to make sure it was cleaned regularly. Its team was also responsible for keeping the premises tidy. It had the sinks it needed for the services it provided. And it had a supply of hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are safe and effective. And it offers flu jabs and keeps appropriate records to show that it has given the right vaccine to the right person. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had automated doors. Its entrance was level with the outside pavement. And the area leading to the counters was kept clear. This made it easier for people to enter the building and access the pharmacy and it services. The pharmacy had some notices that told people about its products and the services it delivered. And it had a small seating area for people to use if they wanted to wait in the pharmacy. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. Members of the pharmacy team were friendly and helpful. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a paid-for delivery service to people who couldn't attend its premises in person. It kept an electronic audit trail for each delivery. And this showed it had delivered the right medicine to the right person. The people who provided the delivery service were based at a different branch. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its flu jab service. And the RP was appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The RP asked another appropriately trained team member to check they had chosen the correct vaccine before administering it. The pharmacy provided substance misuse treatments and a needle exchange service. The pharmacist could supervise the consumption of some substance misuse clients' treatments. And the pharmacy team asked needle exchange clients to return spent sharps within the containers provided and deposit these into a designated receptacle. Members of the pharmacy team responsible for making up people's prescriptions kept the dispensing workstations tidy. They used plastic containers to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They scanned the bar code of the medication they selected to check they had chosen the right product. They gave people a patient information leaflet for each medicine they dispensed. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the RP. 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. The pharmacy used reminder cards and notes to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection 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 knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that

people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And the pharmacy had the resources it needed when its team dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept most of its medicines and medical devices within their original manufacturer's packaging. But a few medicines weren't. And this made it difficult for the pharmacy team to tell if it had all the information it needed if a particular make of medicine was recalled. Members of the pharmacy team checked the expiry dates of medicines at regular intervals. They recorded when they did these. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. And out-of-date CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert.

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 it mostly uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used 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 a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerator's maximum and minimum temperatures. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. But it could do more to make sure its team members store their NHS smartcards securely when they weren't working or not using them.

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.