General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 118-120 Brighton Road, COULSDON, Surrey, CR5 2ND

Pharmacy reference: 1036482

Type of pharmacy: Community

Date of inspection: 02/02/2023

Pharmacy context

This NHS community pharmacy is set on a row of shops in Coulsdon town centre. The pharmacy is part of a large chain of pharmacies. It opens seven days a week. It sells medicines over the counter. 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 supplies multi-compartment compliance packs (compliance packs) to people who need help managing their medicines. 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	1.1	Good practice	The pharmacy identifies and manages its risks very well.
		1.2	Good practice	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
2. Staff	Good practice	2.2	Good practice	The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills.
		2.4	Good practice	Members of the pharmacy team work well together and have a clear work culture of openness, honesty and learning.
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 identifies and manages its risks very well. It has written instructions to help its team members work safely. It continually monitors the safety of its services to protect people and further improve patient safety. 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 log and 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 most people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had a business continuity plan. And this identified the potential risks to the pharmacy, its services and its team in the event of an emergency. The pharmacy had also considered the risks of coronavirus. And, as a result, it had put some screens on its counter to try and stop the spread of the virus. People who worked at the pharmacy 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 regularly by a team based at the pharmacy's head office. Members of the pharmacy team were required to read, complete training on and sign the SOPs relevant to their roles to say they understood them and would follow them. The pharmacy carefully managed its dispensing workflow to reduce the chances of its team making mistakes. It generally kept its pharmaceutical stock alphabetically. And its team separated and highlighted some higher-risk medicines, such as methotrexate, sulfonylureas and quetiapine, from other stock to help reduce the chances of the wrong product being picked. Team members 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 initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the responsible pharmacist (RP). The pharmacy had robust processes to deal with patient safety incidents and dispensing mistakes that were found before reaching a person and those which weren't. And the safety and the quality of its services were monitored at least once a month. Members of the pharmacy team recorded the mistakes they made and any lessons they learnt from them. They reviewed their mistakes regularly to help them spot patterns or trends. And they shared any learnings with one another during team meetings. So, they could try to stop the same sorts of mistakes happening again and improve the safety of the dispensing service they provided. And, for example, they recently strengthened their dispensing process to make sure people got the right number of tablets.

The pharmacy displayed a notice that told people who the 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 shared 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, following recent feedback, the pharmacy team tried to answer people's telephone calls more quickly than it had been doing. 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 team made an appropriate entry on the computer system when a prescription-only medicine was supplied to a person in an emergency. The pharmacy kept records to show which pharmacist was the RP and when. It recorded the details of the private prescriptions it supplied on its computer system. But the name and address of the prescriber weren't always correctly recorded. The pharmacy kept a record for the supplies of the unlicensed medicinal products it made. But its team sometimes forgot to record when an unlicensed medicinal product was received, when it was given out and who it was supplied to.

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 their personal information was gathered, used and shared by the pharmacy and its team. And it had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines people returned to it before being disposed of. 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' (Action Needed Immediately) scheme. And the pharmacy's consulting room could be used by someone as a 'safe space' if they felt they were in danger.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it encourages them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

Inspector's evidence

The pharmacy team consisted of a store manager, two regular pharmacists, a pharmacy technician, seven pharmacy advisors and three other team members who recently joined the pharmacy. And one of the regular pharmacists (the RP), the store manager, the pharmacy technician and two pharmacy advisors were working at the time of the inspection. The store manager was a trained pharmacy advisor. So, they could help the pharmacy team when needed. The pharmacy depended upon its team, colleagues from other branches and sometimes locum pharmacists to cover any absences. People who worked at the pharmacy were up to date with their workload. 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. 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.

The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with their line manager. And, for example, the pharmacy technician recently started a training and development programme to become an accuracy checking pharmacy technician. Team members were encouraged to ask questions, read newsletters from the pharmacy's head office and familiarise themselves with new products. They kept their knowledge up to date by completing online training. They had time set aside while they were at work to train and support their development. But they could choose to train in their own time too. The pharmacy had a culture that encouraged its team to be open and honest about the mistakes people made and share learning at meetings or during one-to-one discussions. This meant it could improve the safety of the services it offered. People who worked at the pharmacy didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They 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 each of them using a different coloured pen to initial dispensing labels, so it was easier to tell who had assembled someone's prescription if something went wrong.

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 and secure. It was professionally presented. And improvements have been made to its layout and its general decoration since its last inspection. But its dispensary had limited workbench and storage space available, and some bulky prescriptions needed to be stored on the floor. And people's compliance packs were assembled on a bench in the stockroom. The pharmacy used its consulting room for the services it offered or if someone needed to speak to a team member in private. And people's conversations in the consulting room couldn't be overheard outside of it. The consulting room couldn't be locked when it wasn't being used. So, members of the pharmacy team needed to make sure its contents were removed or secured when it wasn't being used. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water. The pharmacy was regularly cleaned by a third-party contractor. The pharmacy team was responsible for keeping the premises clean and tidy. And surfaces frequently touched by people were regularly wiped and disinfected.

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 them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually 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 its counter was kept clear. This made it easier for people to enter the pharmacy and access the services offered. The pharmacy had some notices and leaflets 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 routinely asked a person who was prescribed a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed it. And the pressure on local 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 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 it needed for its flu jab service. And the pharmacy team members who vaccinated people were appropriately trained. The vaccinator asked another appropriately trained team member to check they had chosen the correct vaccine before administering it. 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 pharmacy offered a walk-in flu jab service or people could book an appointment. This meant people could be jabbed at a time convenient to them. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. And a brief description of each medicine contained within the compliance pack was provided. But patient information leaflets weren't always supplied. So, sometimes people didn't always have the information they needed to take their medicines safely. 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. And reminder cards and notes were used to alert the team when these items needed to be added or if extra counselling was needed. 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 they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines

and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. 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 an 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. 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. But the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it. 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. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

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 superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each 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. And its team members made sure their NHS smartcards were 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.