General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, The Green, Chiddingfold, GODALMING, Surrey, GU8 4TU

Pharmacy reference: 1036586

Type of pharmacy: Community

Date of inspection: 17/05/2024

Pharmacy context

This NHS community pharmacy is set in the centre of Chiddingfold village. The pharmacy is part of a large chain of pharmacies. It opens six days a week. It sells medicines over the counter. And it dispenses people's prescriptions. The pharmacy delivers the NHS Pharmacy First service to help people who have a minor illness or need an urgent supply of a medicine. And people can visit the pharmacy to get their flu jab or have their blood pressure checked.

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 manages its risks appropriately. It has written instructions to help its team members work safely. It keeps the records it needs to by law. It has the insurance it needs 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 to try to 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 usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had a notice that told people who the responsible pharmacist (RP) was at that time. It had 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 complete training on the SOPs relevant to their roles to show they understood them and agreed to follow them. And they knew what they could and couldn't do, what they were responsible for and when they might seek help. 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. 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). The pharmacy team discussed, reviewed and recorded the mistakes it made to learn from them, and help stop the same sort of things happening again. And, for example, it strengthened its dispensing process to make sure people got the right number of tablets.

Some people have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. It had a leaflet which asked people to share their views and make suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine 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 largely kept adequate records to show which pharmacist was the RP and when. And it kept appropriate records for the supplies of the unlicensed medicinal products it made. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. And the records seen were generally in order.

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 crossed out or removed from the unwanted medicines returned to it before being disposed of. Members of the pharmacy team were required to complete training on data protection 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. And the pharmacy's consulting room could be used by someone if they felt they were in danger.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. 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 store manager, a support pharmacist, a trainee pharmacy technician, a pharmacy advisor, a trainee pharmacy advisor and a medicines counter assistant. The pharmacy depended upon its team, relief or locum pharmacists and colleagues from another Boots branch to cover absences. The people working at the pharmacy during the inspection included a locum pharmacist (the RP), the pharmacy advisor and the trainee pharmacy advisor. The store manager was the pharmacy's regular pharmacist. And they were responsible for leading the pharmacy team and managing the pharmacy. Members of the pharmacy team didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they were up to date with their workload. The RP 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. Team members needed to complete mandatory training during their employment. They were also 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 the pharmacy wasn't busy. They shared learning from the mistakes they made when they could. And they were encouraged to complete training while they were at work. But they could choose to train in their own time. The pharmacy had a whistleblowing policy. Members of the pharmacy team knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And, for example, text messages were only sent to people once their prescription was ready to collect.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was set in a listed building and was subject to strict planning conditions. And this made it difficult for the pharmacy owner to make improvements to the pharmacy's layout and workflow. The pharmacy had a consulting room, a counter, a dispensary, a retail area, a staffroom, a stockroom and a toilet. It generally had the workbench and storage space it needed for its current workload. And its public-facing area was adequately lit and presented. But some of the ceilings were low. And there was a damp patch on a wall in the toilet. The pharmacy wasn't air-conditioned and the lights in its dispensary were noticeably warm. But steps were taken to make sure the premises didn't get too hot. The consulting room was available for services that needed one or if someone needed to speak to a team member in private. It was locked when it wasn't being used to make sure its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had a contract with a pest control company to deal with any unwanted pests. It had the sinks it needed for the services it provided. It had a supply of hot and cold water. And its team was responsible for keeping the premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. And its team is friendly and helps people access the services they need. The pharmacy gets its medicines from reputable sources. And it largely 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 didn't have an automated door. And its entrance wasn't level with the outside pavement. But it had a portable ramp that could be placed outside. And a member of the pharmacy team would open the door when necessary. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy. The pharmacy had some notices that told people when it was open and what services it offered. 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 a new medicine if they wanted to speak to the pharmacist about it. The pharmacy dealt with Pharmacy First referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for some minor illnesses. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a flu jab service. It kept a record for each vaccination it made. And the people who provided the service were appropriately trained. The team members who were 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 routinely provided patient information leaflets with the medicines they dispensed. And assembled prescriptions were not handed out unless their clinical appropriateness had been checked by a pharmacist. The pharmacy usually kept a record of each person involved in making up a person's prescription. And it 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 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. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. 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 most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team usually marked the 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 things 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. It stored its CDs, which weren't exempt from safe custody requirements, securely. Its team recorded the destruction of the CDs that people returned to it. And it kept these and out-of-date CDs separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But a patient-returned medicine that needed to be locked away and a cytotoxic medicine was found in a waste bin not intended for hazardous medicines. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described the actions they took and what records they made when the pharmacy received an MHRA medicines recall.

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 and suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team 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 refrigerator to store pharmaceutical stock requiring refrigeration. And its team checked and recorded the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the Pharmacy First service as well as for measuring a person's blood pressure. And this equipment appeared to be well maintained. 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.