General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 8 High Street, HORLEY, Surrey, RH6 7AY

Pharmacy reference: 1036627

Type of pharmacy: Community

Date of inspection: 16/10/2023

Pharmacy context

This NHS community pharmacy is set in Horley town centre. The pharmacy is part of a large chain of pharmacies. It opens six days a week. It dispenses people's prescriptions. It delivers medicines to people who have difficulty in leaving their homes. And it sells medicines over the counter. The pharmacy provides the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And its pharmacist can check a person's blood pressure.

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 mostly 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 generally log and review the mistakes they make 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

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 computerised 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). And its team had separated some higher-risk drugs, such as methotrexate, sulfonylureas and quetiapine, from other medicines to help reduce the risks of the wrong product being picked. Members of the pharmacy team were required to discuss, review and log the mistakes they made on the computer to learn from them, and help them stop the same sort of things happening again. They had completed some patient safety reviews of the mistakes they had made. And following one of these reviews they recorded their near misses as they happened.

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 kept adequate records to show which pharmacist was the RP and when. It kept records for the supplies of the unlicensed medicinal products it made. But its team could do more to make sure it recorded when an unlicensed medicinal product was received and supplied. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly. And the details of the prescriber were incorrect in some of the private prescription records seen. The pharmacy team gave an assurance that these records would be maintained as they should be.

People using the pharmacy couldn't generally 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. 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 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 as a 'safe space' if they felt they were in danger.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just 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, three pharmacy advisors and a trainee medicines counter assistant. The pharmacy depended upon its team, colleagues from other pharmacies and relief or locum pharmacists to cover absences. And it didn't currently have a permanent pharmacist. The people working at the pharmacy during the inspection included a locum pharmacist (the RP), the store manager and a pharmacy advisor. The store manager was also a pharmacy advisor. And they were responsible for leading the pharmacy team.

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 nearly up to date with their workload. But they sometimes didn't have time to do all the things they were expected to do. 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.

People working at the pharmacy 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 they could. They could share learning from the mistakes they made and were kept up to date when the pharmacy wasn't busy. They were encouraged to complete training while they were at work. But they could choose to train in their own time.

Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to some additional storage units being installed.

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 air-conditioned and bright. Its public-facing area was adequately presented. It had some hand sanitisers and a supply of hot and cold water. Its team and a cleaning contractor were responsible for keeping its premises clean and tidy. But the sink in the dispensary was stained and more needed to be done to make sure this was kept clean. The pharmacy generally had the workbench and storage space it needed for its current workload. But its worksurfaces and floor could become cluttered when it was busy. The pharmacy had a consulting room for the services it offered that required one or if someone needed to speak to a team member in private. People’s conversations in the consulting room couldn’t be overheard outside of it. The consulting room couldn’t be locked. So, its contents needed to be kept secure when it wasn’t being used.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are safe and effective. And it delivers medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. The pharmacy gets its medicines from reputable sources. And it mostly 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 an automated door. And its entrance was level with the outside pavement. These things made it easier for people to enter the building. The pharmacy had a notice that told people when it was open. It had a few leaflets that told people about some of the services it delivered. And it had a small seating area for people to use when 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 a few CPCS referrals. And people benefited from the CPCS as they could access the advice and medication they needed when they needed to. 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. But the people who provided the delivery service were based at a different branch.

The team members who were responsible for making up people's prescriptions tried to keep 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. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the pharmacist. The pharmacy used a handheld device to scan the barcode on each assembled prescription bag before storing it on a shelf. And this helped its team find a person's prescription more quickly. 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. But assembled CD prescriptions awaiting collection weren't always 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 new 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 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 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 some hazardous waste had been put into the wrong pharmaceutical waste bin. 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 showed what records they made when they 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. 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 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 a medical refrigerator to store pharmaceutical stock requiring refrigeration. And though its team was required to check and record the refrigerator's maximum and minimum temperatures on the days it was open, occasionally these haven't been recorded. The pharmacist could check a person's blood pressure when asked. And the monitor used for this service was replaced less than a year ago. 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.