General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 15-19 High Street, WALTON-ON-THAMES, Surrey, KT12 1DG

Pharmacy reference: 1036825

Type of pharmacy: Community

Date of inspection: 09/02/2023

Pharmacy context

This NHS community pharmacy is on a row of shops in Walton-on-Thames. The pharmacy is part of a large chain of pharmacies. It opens six 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 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

Follow this link to find out what the inspections possible outcomes mean

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 adequately. 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 generally 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 usually 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 had put some plastic screens on its counters to try and stop the spread of the virus. The pharmacy team had the personal protective equipment it needed. And hand sanitising gel was available too. The pharmacy 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, sign and complete training on the SOPs relevant to their roles to say they understood them and would follow them. The pharmacy generally stored its pharmaceutical stock in alphabetical order. 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 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 processes to deal with the dispensing mistakes that were found before reaching a person and those which weren't. Members of the pharmacy team generally discussed, recorded 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 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 could share their experiences of using the pharmacy and its services online. 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 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 usually 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 suitable 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 incomplete or incorrect in the private prescription records. And the reason for making an

emergency supply wasn't always recorded properly. The pharmacy was required to keep a record of the supplies of the unlicensed medicinal products it made. But a record for a recent supply seen during the inspection didn't say when the 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 ✔ Standards met

Summary findings

The pharmacy has just enough people in its team to deliver safe and effective care. But its team is sometimes so busy it struggles to do all the things it's 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 store manager, a full-time pharmacy advisor, a part-time pharmacy advisor, a part-time trainee pharmacy advisor and a part-time healthcare assistant. The store manager was a pharmacy advisor. So, they could help the pharmacy team when needed. The pharmacy didn't have a regular pharmacist, and it depended upon locum pharmacists or relief pharmacists so it could open. It also relied upon its team or colleagues from other branches to cover absences. The people working at the pharmacy during the inspection included a locum pharmacist (the RP), a pharmacy advisor, the trainee pharmacy advisor and the healthcare assistant. Members of the pharmacy team were sometimes so busy they struggled to do all the things they were asked to do as they didn't always have enough time to do them. But they were up to date with their workload. 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 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. 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 changes in the way in which people's prescriptions awaiting collection were filed.

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 medium-sized Boots store. And its registered area consisted of a consulting room, two counters, a dispensary and some bays of back wall shelving. The premises were air-conditioned, bright, clean and adequately presented. But some areas were showing signs of wear. The pharmacy generally had the workbench and storage space it needed for its current workload. It used its consulting room for the services it offered that required one and if people needed to speak to a team member in private. The consulting room was usually 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 store was regularly cleaned by a cleaning contractor. And the pharmacy team was responsible for keeping the pharmacy area clean and tidy. The pharmacy had a sink and a supply of hot and cold water. And its team regularly wiped and disinfected the surfaces they and other people touched.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally 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. But it doesn't always give people the information they need to take their medicines safely with their compliance packs. 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 store was located on the high street. Its entrance was level with the outside pavement. And the area leading to the pharmacy was kept clear. But the pharmacy had, since its last inspection, reduced its opening hours and didn't open on Sundays anymore. 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 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 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 offered flu jabs and had the anaphylaxis resources it needed for this service. But it didn't always have an appropriately trained pharmacist available to vaccinate people. And this sometimes made it difficult for the pharmacy team to plan when the service could be delivered and for people to book an appointment in advance. 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, 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. But assembled CD prescriptions awaiting collection weren't marked with the date the 28-day legal limit would be reached and some of them had expired. 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 mostly 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 usually checked and recorded each refrigerator's maximum and minimum temperatures when the pharmacy was open. 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 stored their NHS smartcards 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.