

Registered pharmacy inspection report

Pharmacy Name: Boots, 17 Bartholomew Way, HORSHAM, West Sussex, RH12 5JL

Pharmacy reference: 1073053

Type of pharmacy: Community

Date of inspection: 16/03/2022

Pharmacy context

This is an NHS community pharmacy set on a small parade of shops opposite a doctor's surgery in a residential area of Horsham. The pharmacy opens six days a week. It sells some health and beauty products, including over-the-counter medicines. It dispenses people's prescriptions. It delivers medicines to people who can't attend its premises in person. People can get a flu jab (vaccination) from the pharmacy. And they can collect coronavirus (COVID-19) home-testing kits from the pharmacy too. This inspection took place during the COVID-19 pandemic.

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 identifies and manages the risks associated with its services. It has introduced new ways of working to help protect people against COVID-19. It has written instructions to help make sure its team works safely. It mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong. People who use the pharmacy can provide feedback to help improve the services they receive. Members of the pharmacy team know what they can and can't do, what they're responsible for and when they might seek help. They review the mistakes they make and learn from them to try and stop them happening again. They understand their role in protecting vulnerable people. And they generally keep people's private information safe.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed periodically by a team of people at the pharmacy's head office. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. And, as a result, it had put up plastic screens on its counter to try and stop the spread of the virus. The pharmacy had offered to complete occupational COVID-19 risk assessments for its team members. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They were encouraged to self-test for COVID-19 regularly. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands and used hand sanitising gel when they needed to.

Members of the pharmacy team responsible for making up people's prescriptions had highlighted and separated some packs of medicines that looked alike and whose names sounded alike on the shelves to help reduce the chances of them picking the wrong one. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They generally 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 by the responsible pharmacist (RP) who also initialled the dispensing label. The pharmacy had systems for its team to deal with patient safety incidents. Members of the pharmacy team discussed and recorded the mistakes they made. They reviewed their mistakes periodically to help spot the cause of them. And they shared any learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. And, for example, they strengthened their dispensing process following some mistakes when they hadn't counted out the right number of tablets.

The pharmacy displayed a notice that told people who the RP was. 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 wouldn'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 a complaints procedure. And it had a leaflet that told people how they could provide feedback about it and its services. The pharmacy had received feedback from people online. It asked people for their views and suggestions on how it could do things better.

And, for example, it tried to keep people's preferred makes of prescription medicines in stock when its team was asked to do so.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It kept a record to show which pharmacist was the RP and when. It had a controlled drug (CD) register. And its team regularly checked the stock levels recorded in this register. But the details of where a CD came from weren't always completed in full. The pharmacy kept records of the supplies of the unlicensed medicinal products it made. It recorded the emergency supplies it made and the private prescriptions it supplied electronically. And most of these records were in order. But the details of the prescriber were sometimes incorrect in the private prescription records.

People using the pharmacy couldn't see other people's personal information. The pharmacy's owner was registered with the Information Commissioner's Office. The pharmacy displayed a notice in-store and it had a leaflet that told people how their personal information was gathered, used and shared by the pharmacy and its team. 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 as required by the SOPs. Members of the pharmacy team were required to complete safeguarding training relevant to their roles and training on information governance and data protection. They could refer to the pharmacy's safeguarding policy to help them if they wanted to raise a safeguarding concern. And they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to deliver safe and effective care. But its team sometimes doesn't get time to do all the things it's expected 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 two part-time pharmacists, a full-time store manager, a full-time dispensing assistant, a full-time trainee dispensing assistant and a part-time trainee dispensing assistant. The part-time pharmacists and a relief pharmacist generally covered the days the pharmacy was open. The RP, the store manager, the dispensing assistant and two trainee dispensing assistants were working at the time of the inspection. The pharmacy relied upon its team and team members from other pharmacies to cover any absences or provide additional support when the pharmacy was busy. But it struggled at times to cover absences. And its team members sometimes found it difficult to do all the things they were expected to do as they didn't always have enough time to do them. But the pharmacy team didn't feel its professional judgement or people's safety were affected by the targets the company wanted it and the pharmacy to achieve.

Members of the pharmacy team generally worked well together. So, people were served promptly, and their prescriptions were processed safely. 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, people who were old and people with long-term health conditions to the pharmacist on duty. The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. And they were required to undertake accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their line manager when they could. But they haven't had an appraisal with their line manager for a little while. Team members were encouraged to ask questions and familiarise themselves with new products. They were also asked to read company newsletters and complete online training to make sure their knowledge was up to date. But they didn't always get the time to do so. The pharmacy had meetings and one-to-one discussions to update its team and share learning. It had a grievance and whistleblowing policy. And its team was comfortable about making suggestions on how to improve the pharmacy and its services. Team members knew who they should raise a concern with if they had one. And their feedback led to a second telephone line being installed at the pharmacy.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The registered pharmacy premises were air-conditioned, bright, clean and secure. The pharmacy generally had the workspace and storage it needed. But the worksurfaces could become cluttered when the pharmacy was busy. Members of the pharmacy team were responsible for keeping the premises clean and tidy. But they sometimes didn't get time to do so when the pharmacy was busy. The pharmacy had a consulting room for the services it offered. And this could be used if people 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 was locked when it wasn't being used. So, its contents were kept secure. The pharmacy 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. Its working practices are safe and effective. Its team members are helpful. And they make sure that people have the information they need. So, they can use their medicines safely. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team mostly dispose of people's unwanted medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an automated door. Its entrance was level with the outside pavement. And it had wide aisles. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. 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. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a repeat prescription collection service. And its text messaging service told people when their medicines were ready to collect. This meant that people didn't need to attend or contact the pharmacy to check if it had received their prescription. The pharmacy provided a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person. The people who provided the delivery service were based at one of the company's other pharmacies. The pharmacy supplied COVID-19 tests that people could use in their homes. And these tests were used to help find cases in people who may have no symptoms but were still infectious and could give the virus to others. 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 pharmacy kept a record for each flu jab it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team made sure the sharps bin was kept securely when not in use.

Members of the pharmacy team assembled people's prescriptions in line with the SOPs. They were required to supply people with a patient information leaflet with their prescribed medication. They 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 clear bags for some dispensed items, such as CDs and insulins, 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 team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting, such as a higher-risk medicine, or if other items, such as a refrigerated product, needed to be added. The pharmacy team generally marked prescriptions for CDs with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily within the dispensary within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. It recorded when it had done these checks. And it marked products which were soon to expire to reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. 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 and patient-returned CDs were kept separate from in-date stock. But these had been allowed to build up. 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 team had put some hazardous waste medicines into the wrong type of bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And 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 data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a few 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 maximum and minimum temperatures of this refrigerator. 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.