General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, York House Medical Centre, Heathside Road, WOKING, Surrey, GU22 7XL

Pharmacy reference: 1087441

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

This is a community pharmacy set next to a medical practice in Woking. Most people who use the pharmacy are patients of the medical practice. The pharmacy dispenses NHS and private prescriptions and it sells a range of over-the-counter medicines. It also delivers medicines to people who can't attend its premises in person.

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	1.2	Good practice	The pharmacy continually monitors the safety of its services to protect people and further improve patient safety.
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 continually monitors the safety of its services to protect people and further improve patient safety. Its team members log and review the mistakes they make. So, they can learn from these and act to avoid problems being repeated. The pharmacy has appropriate insurance to protect people if things do go wrong. And it generally keeps all the records it needs to by law. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They work to professional standards and identify and manage risks appropriately. They understand their role in protecting vulnerable people. But they could do more to keep people's private information safe.

Inspector's evidence

The pharmacy only provided essential NHS services to people as its premises were small. Staff responsible for the dispensing process tried to keep the dispensing workstations tidy. They used plastic containers to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who was also seen initialling the dispensing label.

The pharmacy had standard operating procedures (SOPs) in place for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles.

The pharmacy had systems to record and review dispensing errors and near misses. The pharmacy's team members discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes regularly to help spot the cause of them and any trends. So, they could try to stop them happening again and improve the safety of the dispensing service they provide. For example, they have highlighted look alike and sound alike drugs on the dispensary shelves to reduce the risk of them picking the wrong product. And they have reviewed the pharmacy's SOPs and strengthened their process for handing out prescriptions following a mistake when a prescription was given to the wrong person.

The company recently transferred the assembly of the pharmacy's repeat prescriptions to its 'Dispensing Support Pharmacy' (DSP) following a review of the pharmacy's services. This has freed up staff time. So, they could better manage the pharmacy's acute dispensing workload.

The pharmacy displayed a notice that identified the RP on duty. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist.

A complaints procedure was in place and patient satisfaction surveys were undertaken annually. The results of recent patient satisfaction surveys were published online. Details on how patients could provide feedback about the pharmacy were included in the pharmacy's practice leaflet. People could provide feedback about the pharmacy online or by contacting the company's customer care centre. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy's controlled drug (CD) register and its RP records were adequately maintained. The CD register's running balance was checked regularly as required by the pharmacy's SOPs. The nature of the emergency within the pharmacy's records for emergency supplies made at the request of patients didn't always provide enough detail for why a supply was made. The date of prescribing wasn't included in the pharmacy's records for emergency supplies made at the request of practitioners. The details of the prescriber were occasionally incorrectly recorded within the pharmacy's private prescription records. Most of the pharmacy's 'specials' records weren't available for inspection. But one from a recent supply was. And this was in order.

An information governance policy was in place and staff were required to complete online training on it. Arrangements were in place for confidential waste to be collected and sent to a centralised point for secure destruction. Some prescriptions, which were stored on the pharmacy's counter, were in easy reach of people. Staff removed the ones that were accessible. And a member of staff stayed at the counter for the rest of the inspection to make sure the remainder were secure.

A safeguarding policy and a list of key contacts for safeguarding concerns were available. Staff were required to complete safeguarding training relevant to their roles. And they could explain 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 suitably qualified team members to provide safe and effective care. The pharmacy's team members are encouraged to keep their skills up to date. Staff are comfortable about giving feedback to improve the pharmacy's services. They use their judgement to make decisions about what is right for the people they care for. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 53½ hours a week and it dispensed about 7,200 prescription items a month. The pharmacy team consisted of a full-time pharmacist manager, two full-time dispensing assistants and three part-time dispensing assistants. Staff have completed accredited training relevant to their roles. The pharmacy was reliant upon its team members, relief staff and staff from nearby branches to cover any absences. A relief pharmacist (the RP) and four dispensing assistants were working at the time of the inspection.

Staff supported each other so prescriptions were processed in a timely manner and people were served promptly. The RP supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team needed to follow. One of the dispensing assistants described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for infants, people who were pregnant, elderly people or people with long-term health conditions.

Staff performance and development needs were discussed informally throughout the year and at colleague reviews. Members of the pharmacy team were encouraged to ask the pharmacists questions, familiarise themselves with new products, read the company's monthly 'Professional Standard' newsletter and undertake online training to keep their knowledge up to date. Team meetings were held to update staff and share learning from mistakes or concerns. Staff unable to attend these meetings were updated during one-to-one discussions. Members of the pharmacy team felt comfortable in providing suggestions about the pharmacy during team meetings. And they knew how to raise a concern with the persons nominated within the company's whistleblowing policy or anonymously through a telephone hotline. Their feedback led to changes being made to the pharmacy's prescription retrieval process.

The pharmacy's team members didn't feel their professional judgement or patient safety were affected by company targets. Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations were only provided by suitably qualified pharmacists when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare. But it could do more to make sure people have somewhere to wait when it’s busy.

Inspector's evidence

The pharmacy was bright, appropriately presented and air-conditioned. But it was small. Its dispensary had limited storage space and workbench available. And people often had to stand or sometimes wait outside when the pharmacy was busy.

The pharmacy team was responsible for keeping the registered pharmacy area clean and tidy. The pharmacy had a supply of hot and cold water. And it had appropriate handwashing facilities for its staff.

A small consultation room was available if people needed to speak to a team member in private. It was also used for administrative tasks and to store some of the pharmacy’s paperwork and people’s purchases made through the company’s website. But it was locked when not in use to make sure its contents were kept secure.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It provides services that most people can access easily. It delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. And it gets its medicines from reputable sources and it stores them appropriately and securely. The pharmacy's team members check stocks of medicines to make sure they are fit for purpose. They generally dispose of people's waste medicines safely too.

Inspector's evidence

The pharmacy's services were advertised in-store and were included in the pharmacy's practice leaflet. There was no automated door into the pharmacy. But its entrance was level with the outside pavement. And staff opened the door, when necessary, to help people access the premises. The pharmacy team knew what services the pharmacy offered and where to signpost people to if a service couldn't be provided.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. An audit trail was maintained for each delivery and people were asked to sign a delivery record to say they had received their medicines. The delivery drivers were based at another store. The pharmacy provided over 30 MURs and one to two NMS consultations a month. People provided their written consent when recruited for these.

The pharmacy displayed a small notice informing people that some prescriptions may be made up at another of the company's pharmacies. But the pharmacy team didn't routinely tell people about this or ask them for their consent for this to happen. The pharmacy team couldn't use the computer terminal in the consultation room to input the details of people's prescriptions which were to be assembled at the company's DSP. So, staff could become distracted while doing this task by people or colleagues as they could only use the computer terminals in the dispensary.

Clear bags were used 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. A 'counselling reminder' card and a 'pharmacist information form' were used to alert the person handing the medication over that these items had to be added or if extra counselling was required. Prescriptions for CDs were marked with the date the 28 day legal limit would be reached to ensure supplies were made lawfully. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare and Phoenix, to obtain its medicines and medical devices. It kept its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Its stock was subject to date checks, which were documented, and products nearing their expiry dates were appropriately marked. It stored its stock, which needed to be refrigerated, appropriately between 2 and 8 degrees Celsius. But some food was also stored amongst stock in the pharmacy's refrigerator. Staff removed this when they were told about it.

The pharmacy stored its CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. Staff were required to keep patient-returned and out-of-date CDs separate from in-date stock. But out-of-date CDs have been allowed to accumulate and needed to be destroyed in the presence of an authorised witness.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't verifying nor decommissioning stock at the time of the inspection as the pharmacy didn't have the appropriate equipment nor computer software to do so. The pharmacy's SOPs had been reviewed to reflect the changes FMD would bring to the pharmacy's processes. And the pharmacy team didn't know when the pharmacy would become FMD compliant.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was emptied into a plastic tray and was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Suitable pharmaceutical waste receptacles were available and in use. But some hazardous waste was found in a receptacle intended for non-hazardous waste.

A process was in place for dealing with recalls and concerns about medicines and medical devices. Drug and device alerts were retained and annotated with the actions taken following their receipt.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had up-to-date reference sources available. And its pharmacy team could access information from the chief pharmacist's office. It had a range of clean glass measures and equipment for counting loose tablets and capsules too. A medical refrigerator was used to store pharmaceutical stock requiring refrigeration. And its maximum and minimum temperatures were checked and recorded regularly.

The pharmacy's name and telephone number were on its dispensing labels. But its address wasn't. And there were a few branches of Boots in Woking. So, people could be confused about which pharmacy had supplied their medicines.

Access to the pharmacy computers and the patient medication record system was restricted to authorised personnel and password protected. The computer screens were out of view of the public. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary.

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.