General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, The Villages Medical Centre, Send Barnes Lane, Send, WOKING, Surrey, GU23 7BP

Pharmacy reference: 1088131

Type of pharmacy: Community

Date of inspection: 12/07/2023

Pharmacy context

This NHS community pharmacy is set next door to a GP surgery in the Surrey village of Send. 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 delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And its team can check a person's blood pressure.

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 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 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 put some plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had computerised standard operating procedures (SOPs) for the services it provided. But its team couldn't access these easily during the inspection. The SOPs 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. They 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. The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time. 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). Members of the pharmacy team had separated some higher-risk medicines, such as methotrexate, sulfonylureas and quetiapine, from other stock to help reduce the risks of the wrong product being picked. They were required to discuss, review and record the mistakes they made to learn from them, and help them stop the same sort of things happening again. The pharmacy team showed it had completed some patient safety reviews of the mistakes it had made. But the team members working at the time of the inspection couldn't show what mistakes had been recorded recently on the computer. And this meant they couldn't complete the most recent patient safety review to help them strengthen their processes further.

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 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 records to show which pharmacist was the RP and when. And these were mostly in order. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But when the pharmacy received an unlicensed medicinal product, when it supplied it and who it supplied it to weren't always recorded. 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 and the date the prescription was issued were incorrect in some of the private prescription records seen.

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 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 are often busy doing all the things they're asked to do. But they do the right training for their roles. And they work well together and use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist manager, a full-time trainee pharmacy technician, five part-time pharmacy advisors and a part-time trainee pharmacy advisor. The pharmacy depended upon its team, colleagues from nearby branches or locums to cover absences. The people working at the pharmacy during the inspection included a locum pharmacist (the RP), the trainee pharmacy technician, three pharmacy advisors and the trainee pharmacy advisor. The pharmacy had seen an increase in its dispensing volume following the closure of some local pharmacies. And, as a result, people were asked to order their prescriptions earlier than they usually would to give their surgery and the pharmacy the time they needed to process and make up their prescription. This meant the pharmacy team was sometimes too busy to do all the other things it was asked to do. And, for example, some team members started earlier than they should do to keep the pharmacy clean and complete any outstanding routine tasks.

The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. Members of the pharmacy team were a day or so behind with their workload. But they worked well together and helped each other to serve people and make sure prescriptions were dispensed safely. And they didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. 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 the 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 during ad hoc meetings. They were encouraged to complete training. They were sometimes too busy to train 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 the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback about the increase in their dispensing workload has led to the company to consider assembling some of the pharmacy's repeat prescriptions at its centralised hub pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy shared a building with a GP surgery. But it had its own separate entrance. The pharmacy was air-conditioned, bright and secure. Its public-facing area was adequately presented. And its team members were responsible for keeping its premises clean and tidy. The pharmacy generally had the workbench and storage space it needed for its current workload. But it sometimes had difficulty storing large prescriptions and bulky items 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, the pharmacy team needed to make sure its contents were kept secure when it wasn’t being used. The pharmacy had some sinks and a supply of hot and cold water. And its team wiped and disinfected the surfaces they and other people touched when they weren’t busy doing all the other things they needed to do.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can usually access easily. 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 stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they usually 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. But its entrance was level with the outside pavement. And people who couldn't open the door easily, such as people with pushchairs or wheelchairs, relied upon the pharmacy team or other people to help them access the pharmacy. 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 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 generally 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. 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 in alphabetical order. 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. 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, for example, the pharmacy team had removed and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. But the team could do more to make sure it can demonstrate the actions it took when it received a 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 mostly uses its equipment to make sure people's personal information is kept secure. And its team usually 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 usually 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 on the days the pharmacy was open. Members of the pharmacy team could check a person's blood pressure when asked. And the monitors they used to do this were new. 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 or using them.

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.