General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, St. Lukes Surgery, Warren Road, GUILDFORD, Surrey, GU1 3JH

Pharmacy reference: 1091544

Type of pharmacy: Community

Date of inspection: 24/05/2023

Pharmacy context

This NHS community pharmacy is in a GP surgery in a residential area of Guildford. The pharmacy is part of a large chain of pharmacies. It opens five 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 provides a substance misuse treatment service. It supplies multi-compartment compliance packs (compliance packs) to a few 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 its team 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 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 up-to-date 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. 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. It stored its pharmaceutical stock in alphabetical order. 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 initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by 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). 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, document and review the mistakes they made to learn from them. And to help them try to stop the same sort of things happening again. But they sometimes forgot to record the near misses they made. So, they could have missed opportunities to spot patterns in the mistakes they made and help them strengthen the pharmacy's dispensing process further.

People could share their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. And it had a leaflet which asked people to share their views and make suggestions about how the pharmacy could do things better. 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 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 the date an unlicensed medicinal product was received at the pharmacy wasn'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 occasionally the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't recorded properly.

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. But team members are sometimes so busy they struggle to do all the things they are 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, two part-time pharmacy advisors and a part-time trainee pharmacy advisor. And the store manager was a pharmacy technician. The pharmacy had a vacancy for a full-time team member. It didn't have a regular pharmacist, and it depended upon locum or relief pharmacists so it could open. It also relied upon its team members or colleagues from other branches to cover absences. The people working at the pharmacy during the inspection included a relief pharmacist (the RP), a store manager from another branch and two pharmacy advisors. And the area manager attended the pharmacy during the inspection to provide additional pharmacist support. Members of the pharmacy team were sometimes under pressure to do all the things they were asked or expected to do as they didn't always have enough time to do them. And they were a day or so behind with their workload. But 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 make sure prescriptions were dispensed safely. The area manager gave an assurance that the pharmacy would have the right number of people working at the right time to make sure it could continue to deliver its services safely.

The pharmacists 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 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 or by a mobile phone messaging application. They were encouraged to complete training. But they were often too busy to train while they were at work, so they usually trained 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 led to them re-introducing a written log to record the near misses they made.

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 had the workbench and storage space it needed for its current workload. It had a consulting room for the services it offered that required one and if someone needed to speak to a team member in private. The consulting room was 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 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 were expected 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 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. The pharmacy had a notice that told people when it was open. It had reduced its opening hours since its last inspection. It was closed for an hour during the day. And it didn't open on Saturdays anymore. The pharmacy 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 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 patient information leaflets and a brief description of each medicine contained within the compliance pack were provided. So, people had 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. 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 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. Members of the pharmacy team 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 suitable pharmaceutical waste bin. 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 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 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 monitor they used to do this was changed regularly. 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.