General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 57 High Street, EGHAM, Surrey, TW20 9EX

Pharmacy reference: 1091661

Type of pharmacy: Community

Date of inspection: 21/07/2022

Pharmacy context

This is an NHS community pharmacy set in Egham town centre. The pharmacy is part of a large chain of pharmacies. It opens six days a week. It sells a range of 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. And it supplies substance misuse treatments. The pharmacy provides multi-compartment compliance packs (compliance packs) to help people take their medicines. And people can get a winter flu vaccination from the pharmacy.

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 adequately manages its risks. It has written instructions to help its team works 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 can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they talk to each other about the mistakes they make. So, they can learn from them.

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 considered the risks of coronavirus (COVID-19). And, as a result, it completed an occupational risk assessment for its team members and put some plastic screens on its counters to try and stop the spread of the virus. Team members were encouraged to self-test for COVID-19. They knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was freely available.

The team members responsible for making up people's prescriptions kept the dispensing workstations tidy. 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 processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Members of the pharmacy team recorded the mistakes they made on the computer and discussed them to learn from them. And, for example, the dispensing process was strengthened following some mistakes when too many or too few tablets were dispensed. But the pharmacy team hadn't reviewed the mistakes it had made for several weeks. So, it may have missed opportunities to spot patterns or trends in the mistakes it made and take steps to reduce the chances of the same sort of things happening again.

The pharmacy displayed a notice that told people who the RP was at that time. Members of the pharmacy team were required to wear name badges which identified their roles within the pharmacy. 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 also 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 had a complaints procedure. And in-store leaflets asked people to share their views and suggestions about how the pharmacy could do things better. Some people shared their experiences of using the pharmacy and its services online. And, for example, their feedback led to the team members trying to answer the telephone as quickly as they

could when they weren't busy.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. It recorded the emergency supplies it made and the private prescriptions it supplied on its computer. 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, and a few entries in one section had been crossed out. The pharmacy generally kept appropriate records for the supplies of the unlicensed medicinal products it made. But its team sometimes forgot to record when an 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 displayed an in-store notice 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. And it had policies on information governance and safeguarding. Members of the pharmacy team were required to complete safeguarding training relevant to their roles and training on information governance. 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. 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. 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 team was made up of a full-time pharmacist, two part-time pharmacists, a full-time store manager, a full-time pharmacy advisor, two part-time pharmacy advisors, a part-time trainee pharmacy advisor and a full-time medicines counter assistant (MCA). A locum pharmacist (the RP), the store manager, the MCA and a pharmacy advisor from a neighbouring branch were working at the time of the inspection. The pharmacy relied upon its team, team members from other branches and locum pharmacists to cover absences or provide additional support when the pharmacy was busy. Members of the pharmacy team 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 and people with long-term health conditions to the pharmacist on duty.

People working at the pharmacy needed to complete mandatory training during their employment. They were required to do accredited training relevant to their roles too. They discussed their performance and development needs with their line manager when they could. They were kept up to date and could share learning during regular team meetings. And they were encouraged to complete online training when the pharmacy wasn't busy to make sure their knowledge was up to date. Members of the pharmacy team didn't feel the targets they were set stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led them to review their ordering process.

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 registered pharmacy premises were air-conditioned, bright, secure and professionally presented. The pharmacy generally had the workspace and storage it needed. It used a cleaning company to make sure it was cleaned regularly. And the pharmacy team was also responsible for keeping the premises tidy. 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. But the consulting room couldn’t be locked when it wasn’t being used. So, the pharmacy team needed to make sure 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 generally safe and effective. And its team is helpful. Members of the pharmacy team largely 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. 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.

Inspector's evidence

The pharmacy had automated doors. 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 help and advise them. 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. The people who provided the delivery service were based at another store. And an audit trail was kept for each delivery to show that the right medicine was delivered to the right person. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. Its team recently reviewed whether a compliance pack was still suitable for the person it was supplied to. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. But patient information leaflets weren't supplied every time a compliance pack was dispensed. 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 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 used reminder cards and notes 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. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Team members marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines at regular intervals, which they recorded, and before they dispensed them. 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 the 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. And out-of-date and patient-returned CDs were kept separate from in-date stock. 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 bin for its team to put hazardous waste medicines in. 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 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 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 refrigerator's maximum and minimum temperatures. The pharmacy positioned its computer screens so these could only be seen by a member of the pharmacy team. It restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password.

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.