

Registered pharmacy inspection report

Pharmacy Name: Geloo Brothers Ltd, 13-14 Union Street, DARWEN,
Lancashire, BB3 0DA

Pharmacy reference: 1033370

Type of pharmacy: Community

Date of inspection: 10/05/2024

Pharmacy context

This community pharmacy is in a residential area in the town of Darwen, Lancashire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy delivers some medicines to people's homes and provides the NHS Pharmacy First service.

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 suitably manages the risks associated with the services it provides to people. The pharmacy keeps people's sensitive information secure, and it is suitably equipped to safeguard vulnerable adults and children. The pharmacy's team members discuss any mistakes made during the dispensing process to help them learn from them. And they implement changes to the way they work to reduce the risk of similar mistakes recurring.

Inspector's evidence

The pharmacy held a set of written standard operating procedures (SOPs). The SOPs used to support team members in completing various tasks. The SOPs covered many processes including managing dispensing incidents and controlled drug requirements. However, they did not cover every process. For example, the process of checking the expiry dates of the pharmacy's medicines. Team members explained they were required to read the SOPs that were relevant to their roles in the first few months after commencing employment at the pharmacy. But the pharmacy did not keep records to verify this. Team members were aware of the tasks they could and could not complete in the absence of a responsible pharmacist (RP).

Team members demonstrated how they used an electronic system to record mistakes made and identified during the dispensing process. These were called near misses. They recorded various details including the time and date the near miss occurred, as well as any mitigating factors. This supported the team to identify any trends or patterns and subsequently implement changes to the way team members worked to help improve patient safety. Team members explained that they did not always have the time to record each near miss. And so, they may have missed some opportunities to learn from their mistakes. Team members highlighted several examples of changes they had implemented. These included the separation of medicines that had similar names or similar looking packaging. These medicines were known as LASAs. There was a notice displayed in the dispensary which listed examples of common LASAs. The pharmacy used the same electronic system to record dispensing incidents where mistakes were identified after people had been supplied their medicines. Team members held a team meeting whenever such an incident was identified. They discussed why the mistake might have happened and what they could do to reduce the risk of recurrence. Such incidents were escalated to the pharmacy's superintendent pharmacist (SI) for analysis.

The pharmacy had a procedure to support people in raising concerns about the pharmacy. It was outlined via a notice displayed in the pharmacy's retail area. Any concerns or complaints were usually raised verbally with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's SI team. The team took the time to investigate and resolve any concerns that were raised.

The pharmacy had current professional indemnity insurance. It was displaying a RP notice which showed the full name and GPhC registration number of the RP on duty. A sample of the RP record inspected was completed correctly. The pharmacy held electronic controlled drug (CD) registers. The balances recorded in the registers were checked when a CD was dispensed, or the pharmacy received a delivery of new stock. A random check of two CDs showed that the physical stock matched what the pharmacy had recorded in its registers. The pharmacy did not keep records of each CD that was

returned to the pharmacy. The importance of doing so was discussed with the RP.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate container to avoid a mix up with general waste. The confidential waste was periodically destroyed via shredder. Team members understood the importance of securing people's confidential information. They described how they offered people the use of the pharmacy's consultation room if people felt uncomfortable discussing their health in the retail area. The team members present during the inspection confirmed they had completed training on General Data Protection Regulation (GDPR). The RP had completed safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy did not have a written safeguarding reporting policy or procedure, to support team members in raising a safeguarding concern. However, team members described examples of situations where they would raise a safeguarding concern. And they were aware of the contact details of the local safeguarding teams.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs a suitable number of team members to manage the workload safely. Team members are supported by the pharmacy to complete training courses. They provide feedback on the pharmacy's services to help improve service delivery.

Inspector's evidence

The RP was the pharmacy's full-time pharmacist and had worked at the pharmacy for 27 years. During the inspection, the RP was supported by two full-time trainee dispensers and a full-time qualified pharmacy assistant who was training to qualify as an accuracy checking pharmacy technician (ACPT). The pharmacy also employed a part-time ACT and a part-time delivery driver. Team members covered each other's absences. The pharmacy employed locum pharmacists when the RP was absent. Team members were observed working well and supporting each other throughout the inspection. They were dispensing prescriptions well in advance of when they expected people to collect their medicines. The dispensers were observed asking appropriate screening questions before making any sales of medicines. And they involved the RP if they had any queries to ensure sales were appropriate.

Team members received regular support to help them complete any training courses. The trainee dispensers described how they received day-to-day support from the RP but often completed formal training in their own time. The team held ad-hoc training meetings which were led by the RP. The team had recently discussed the NHS Pharmacy First service. They discussed how they could manage the dispensing workload while offering the service efficiently. The pharmacy had an informal annual appraisal process. This was in the form of a one-to-one conversation between the RP and a team member. They discussed performance within their role and any development opportunities.

The pharmacy did not set any service-based targets for the team to achieve. Team members explained they were focused on providing an efficient service for the local community. They described how they felt confident in providing feedback on ways to improve the pharmacy's service delivery. For example, the team had recently discussed updating an area of the dispensary where it stored commonly dispensed medicines. This helped the team reduce the time people had to wait for their prescriptions to be dispensed. The pharmacy had a whistleblowing policy to support team members to raise a concern anonymously.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. And the premises are well maintained. The pharmacy has a private consultation room which is suitable for people to have confidential conversations with team members about their health.

Inspector's evidence

The pharmacy premises were kept secure and were well maintained. The dispensary was spacious with several benches used for dispensing. They were kept clear and tidy throughout the inspection. Team members explained that maintaining their workspace in this way was important in supporting them to dispense safely and efficiently. The RP used a separate bench to complete the final check of prescriptions. The pharmacy had sufficient space to store its medicines. Floor spaces were mostly clear however some bags of medicines awaiting collection were stored on the floor of the dispensary. This created a risk of a trip or a fall. The risk was discussed with the team. The pharmacy had toilet facilities for its team. There was a hot water supply. The pharmacy was cleaned regularly to maintain a hygienic environment.

There was a spacious and tidy consultation room available for people to use to have confidential conversations with team members about their health. The pharmacy had separate sinks available for hand washing and for the preparation of medicines. Team members controlled unauthorised access to restricted areas of the pharmacy. Lighting was bright in the dispensary and retail area.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers people a range of services which are accessible and managed efficiently. The pharmacy generally manages and stores its medicines correctly. Team members respond appropriately when the pharmacy receives alerts about the safety of medicines.

Inspector's evidence

The pharmacy was accessed via a small step to the automatic entrance door. The pharmacy did not have a ramp available to help people with mobility issues access the pharmacy. Team members described how they would prioritise people who could not access the pharmacy by speaking to them at the entrance door. The pharmacy had the facility to provide large-print labels to help people with a visual impairment. Team members knew how to use translation applications to support people who did not speak English. The pharmacy advertised its opening hours on its entrance door. The pharmacy closed between 12.45 and 14.00 on Fridays but this was not clearly outlined. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They were aware of recently issued legislation to ensure people received valproate in the original manufacturers packaging. The team had recently started providing the NHS Pharmacy First service. The pharmacy held the appropriate documentation to provide the service and all team members had undertaken appropriate training to support them in managing the service. The RP had access to supportive information including current patient group directions (PGDs), clinical pathways and the service specification to help support the safe delivery of the service.

Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. Team members used alert stickers to attach to bags containing dispensed medicines to remind them of a task they needed to complete before handing the medicines to the appropriate person. For example, they used 'fridge' stickers to remind them to retrieve a medicine stored in the pharmacy's fridge. The pharmacy offered a delivery service and kept records of completed deliveries. However, people were not asked to sign to confirm receipt of their medicines. This increased the risk of the pharmacy being unable to resolve a discrepancy. The pharmacy kept prescriptions that had not been dispensed in full in a separate basket. For example, if a medicine was out of stock.

The pharmacy stored its Pharmacy (P) medicines behind the pharmacy counter to protect the medicines from self-selection. Team members were experienced in managing requests for P medicines. They were aware of the P medicines that were at risk of misuse and were vigilant to repeat purchases. They asked for support from the RP in situations where they felt unsure about the sale of a high-risk P medicine. The pharmacy had a process for the team to follow to ensure medicines were within their expiry date before being supplied to people. However, the team was unable to demonstrate any records to confirm when the process had been completed. Team members were seen checking the expiry dates of medicines during the dispensing process which mitigated the risk of an expired medicine being supplied to people. No expired medicines were found following a check of around 20 randomly selected medicines. The pharmacy kept most of its prescription-only medicines on shelves and in drawers in the dispensary. These medicines were kept tidily. Different strengths of the same medicine were kept apart

to reduce the risk of picking errors being made. The pharmacy used domestic-grade fridges for storing medicines that required cold storage. Team members recorded the temperature ranges of the fridges each day. A sample of the records showed the fridges were operating within the correct temperature ranges. However, on the day of the inspection the fridge's operating temperature was not within the correct range. The RP gave assurances that the fridge would be monitored hourly, and action would be taken if the fridge continued to operate outside the correct range. The team received medicine alerts electronically but did not keep a record of the checks it made in response to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

The pharmacy used a range of CE marked measuring cylinders. There was a suitable, electronic blood pressure monitor to support the team in measuring people's blood pressure. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people could not see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private.

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.