General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Barrow Pharmacy, Barrow Hill Surgery, Barrow Hill, Barrow, BURY ST. EDMUNDS, Suffolk, IP29 5DX

Pharmacy reference: 1120427

Type of pharmacy: Community

Date of inspection: 13/04/2023

Pharmacy context

This community pharmacy is in the same building as a GP surgery in a village near Bury St Edmunds and provides pharmacy services largely to people registered with the surgery. Its main activity is dispensing NHS prescriptions, some of which it delivers to people at home. It also supplies some medicines in multi-compartment compliance packs when people need this level of support. It offers seasonal flu vaccinations and travel health services. And the pharmacist provides the Community Pharmacist Consultation 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

Overall, the pharmacy manages the risks associated with its services effectively. It generally makes the records it needs to by law within the required timescales. And the pharmacy team members learn from their mistakes so they can make their services safer. It has up-to-date procedures which tell staff how to work safely. But not all of its team members have read these yet, so may not always be aware of best practice. It largely protects people's information though information on medicines waiting to be collected could be better protected.

Inspector's evidence

One of the pharmacy's owners provided most of the responsible pharmacist (RP) cover at the pharmacy. They were present during the inspection alongside another regular pharmacist who was the acting RP. The pharmacy had introduced new written standard operating procedures (SOPs) in February 2023 and the team was in the process of reading these. The documents were kept at the pharmacy for reference. When asked, team members were aware of when they needed to refer queries to the RP. They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products, including medicines containing codeine. The pharmacy did not sell codeine linctus or Phenergan elixir over the counter and the team was aware of the abuse potential of these medicines.

The pharmacy kept a record about mistakes made and corrected during the dispensing process (known as near misses). There was some evidence that the records were reviewed regularly, and the pharmacy had identified ways to prevent similar mistakes happening in future. For example, the team was now ticking the medicine name on the product and the prescription to confirm the right item had been selected. There was also a process to record and review dispensing mistakes which had reached patients to learn from these events. To prevent common selection errors of medicines which sounded or looked similar, for example sertraline and losartan, or choosing the wrong formulations, storage locations were separated. As many of the staff were part-time, information about learning from mistakes and other important information was shared via a private messaging app group and a communications book in the pharmacy.

Staff were able to explain how a complaint should be handled and would refer to the pharmacist on duty when needed. There was information in the pharmacy leaflet about how people could raise a complaint about the pharmacy, and this was on display in the shop area. The pharmacist explained how issues would be escalated to the superintendent (SI) where needed and they would contact people to try to resolve concerns.

The pharmacy had professional indemnity and public liability insurance in place. There was a notice displayed for the public showing details of the current RP on duty. The record about the RP was available and it was largely complete; it was kept electronically. Records viewed about controlled drugs (CDs) were up to date. Running balances were recorded and checked regularly. The recorded stock of three items chosen at random agreed with physical stock. CDs returned by people for destruction were recorded in a designated book; there were a number of these returned recently waiting to be destroyed. Records about unlicensed specials supplied to people contained all the required

information. Records about private prescriptions were kept electronically. Records viewed about recent prescriptions dispensed did not have the correct prescriber details listed and the date of the prescription was not always entered correctly. The pharmacy agreed to review how these records were made in future to ensure the correct information was included.

When asked, staff could describe the need to keep people's information private. There were procedures to protect people's information. Computer screens containing patient information could not be seen by the public. Confidential waste was separated from normal waste and disposed of securely. Prescriptions waiting collection were kept behind the counter. Due to limited storage space and the size of the premises, some patient information (names and addresses) could be seen from the customer side of the counter.

The team members and pharmacists had completed formal training about safeguarding at levels which were appropriate for their roles. The pharmacy had not had to respond to any safeguarding concerns but knew who to refer these to if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload. And they have completed or are enrolled on the right training for the roles they undertake. However, the pharmacy doesn’t provide ongoing training for members of staff who have completed their accredited qualifications. So, it may not always be able to identify and address any ongoing learning needs to help keep the team members' skills and knowledge up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team was made up of the RP, a pharmacy technician and a trainee dispenser who had just started their course. A trainee medicines counter assistant and a trained dispenser were not in. The pharmacy also had two delivery drivers. As described in principle one, two of the pharmacist owners also worked at the pharmacy and one came to the pharmacy during the inspection. The team was able to cope with the workload during the visit.

Members of staff had completed or were enrolled on the right training for their roles and there were some certificates available to evidence this. The team appeared to work well together and were seen helping each other throughout the visit. There was some support to help the team members complete accredited training. However, the pharmacy didn’t currently have a formal training plan to identify and address ongoing learning needs of all the team. The pharmacist said they would look at developing this for the team.

The team members could share ideas about how to make the pharmacy work more efficiently and these would be listened to. The trainee dispenser had created a planner to help organise the preparation of multi-compartment compliance packs more effectively. To make sure information was shared with team members who were not in at the same time, the team used a communications book and a private messaging app. The team members were not set targets and had potential routes to escalate concerns about the pharmacy should the need arise.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are small but are adequate to provide the pharmacy’s services safely.

Inspector's evidence

The pharmacy was in the same building as a GP surgery and shared a main entrance and waiting area with the surgery. The dispensary was separated from the shop floor and it had a sink for preparing medicines. This was equipped with hot and cold running water. Staff facilities were shared with the surgery. The premises were small and had very limited storage space, but the team was trying to work as safely as possible in this environment.

There was a small, private, consultation room to one side of the medicines counter which afforded an area for people to have a conversation in private with the pharmacy team or receive services. A table in the room could be removed to allow access for people in wheelchairs. There was no confidential paperwork left on display in the room.

The lighting and ambient temperatures during the visit were suitable for the activities undertaken and for storing medicines. The pharmacy was reasonably clean. Medicines were stored behind the medicines counter and in the dispensary and could not be reached by members of the public. The premises could be secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages its services effectively. The pharmacy has safe systems to dispense medicines, administer flu vaccinations, and prepare compliance packs. And the pharmacy generally stores and manages its medicines appropriately. However, the pharmacy could do more to make sure that people who receive prescriptions for higher-risk medicines get all the information and advice they need to take their medicines safely.

Inspector's evidence

The pharmacy displayed a range of leaflets close to the counter offering advice about health matters. People waiting for pharmacy services could use the surgery's seated waiting area which was close by. To help people who could not visit the pharmacy in person, the pharmacy delivered medicines to some people. It kept an electronic record of these deliveries which was updated in real time, helping the pharmacy answer queries from people when the driver was mid delivery. The pharmacy also scheduled some repeat deliveries and would check to make sure prescriptions were issued so these deliveries wouldn't be missed.

During the dispensing process, baskets were used to keep prescriptions for different people separate. Different coloured baskets were sometimes used to prioritise the workload. Team members initialled the dispensing labels to create an audit trail, showing who had dispensed and checked each item.

The pharmacy supplied medicines in multi-compartment compliance packs to some people who lived in their own homes. The dispensers prepared these packs in a separate room, away from other dispensing activities. The pharmacy had individual records for the people receiving these packs and added notes to these records when there were changes or other interventions. Any changes that had not been notified to the pharmacy were queried before the packs were prepared. The packs were labelled with the dose but, when first reviewed during the inspection, additional warnings were not always added. The labelling system was subsequently changed to allow this to happen for all packs in future. Dispensed packs were sealed as soon as possible after preparing. Patient information leaflets were supplied every four weeks. To help a person with sight problems, the pharmacy tried to stick to the same brands of medicines so the contents of the packs would feel the same.

The pharmacy had the current safety literature about pregnancy prevention to provide to people when supplying valproate. The team was aware of the updated guidance about supplying this medicine safely including supplying medicines in the manufacturers' original packs. A recent audit had been conducted and the pharmacist explained how patients had been contacted to discuss the need for effective contraception. With regards to other higher-risk medicines, methotrexate was stored in a separate drawer to reduce picking errors. The pharmacy was satisfied that the surgery had very good systems in place to make sure people had the necessary blood tests for oral anticoagulants, methotrexate and lithium. (The vast majority of the prescriptions it dispensed were issued by the surgery.) However, the pharmacy did not have any prompts for staff to check about possible side effects when handing higher-risk medicines out to people. The pharmacist agreed to review this to make sure there was an opportunity to provide counselling to people when needed.

The pharmacy highlighted prescriptions for CDs requiring safe custody so that members of staff could check they were still valid when handing the medicines out. But the same step wasn't always taken for CDs that did not need to be kept in the CD cabinet. However, prescriptions waiting collection were checked regularly and returned if uncollected for a month. This minimised the chance of CDs being handed out beyond the valid date of the prescription.

The pharmacist could provide evidence about the training they had done to administer flu vaccinations under a patient group direction (PGD). And showed how records about administration were made on people's patient medication record. Consent forms for this service were kept. And the PGD that had been in use during the most recent season was in date.

The pharmacy got its medicines from several licensed suppliers. Medicines were generally stored in an organised manner on shelves in the dispensary though storage space was limited. Waste medicines were stored in designated bins. The pharmacy had a date-checking matrix and there was evidence that stock was date checked regularly. When stock was checked during the visit, there were no out-of-date medicines found. Short-dated medicines were highlighted to alert the team members when dispensing and to help remove these from shelves at an appropriate time. A very small number of tablets had been deblistered into plain bottles; these were generally from the preparation of compliance packs. The containers did not include information about the manufacturer or when the tablets had been decanted. This would make it harder to assess their suitability for dispensing in future. The pharmacist agreed to review the process for labelling these containers in future.

Medicines that required refrigerated storage were kept in the pharmacy fridge. Maximum and minimum fridge temperatures were monitored, and the electronic records seen were within the required range. There was enough storage capacity in the fridge and no evidence of ice build-up.

The pharmacy received safety alerts about medicine recalls via email and kept an audit trail to show that stocked medicines were checked to see if any were affected by the alerts. When asked, team members could correctly explain the process they followed about these alerts. It had acted on the recent recall of pholcodine-containing medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And, on the whole, it keeps its equipment clean.

Inspector's evidence

The pharmacy had a range of validated glass measures for dispensing liquid medicines. Some of these were heavily scaled making it harder to judge the level of liquids. The pharmacist agreed to treat these to remove the scale.

Computer screens containing patient information could not be seen by members of the public and the pharmacy team had cordless phones so could hold private conversations out of earshot of the public. The patient medication record system was password protected.

The pharmacy fridge was of a suitable size for the volume of medicines that needed refrigeration. And the maximum and minimum temperatures were checked and recorded. The fridge temperature at the time of the visit was within the required range. And records seen showed this to have been the case over recent weeks. The CD cabinet had sufficient space and was kept secure. There was a process to test electrical equipment to make sure it was safe.

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.