General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Boots, Alfred Barrow Health Centre, Duke Street, Barrow-in-Furness, Cumbria, LA14 2LB

Pharmacy reference: 9011246

Type of pharmacy: Community

Date of inspection: 05/05/2021

Pharmacy context

This is a community pharmacy in the town of Barrow-in-Furness, Cumbria. The pharmacy is inside a health centre. Its main services include selling over-the-counter medicines and dispensing NHS prescriptions. And it delivers medicines for some people to their homes. Some of the pharmacy's prescriptions are dispensed at a central hub. The inspection was completed during the Covid-19 pandemic.

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	1.2	Good practice	The pharmacy's team members are good at learning from the mistakes they make during the dispensing process. They put measures in place to reduce the risk of similar errors happening again and therefore help improve people's safety.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members with a structured training programme to help and support them in improving their knowledge and skills.
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 identifies and manages risks with its services. And it effectively manages the risks with infection control during the pandemic to help keep members of the public and team members safe. It maintains the records it needs to by law and keeps people's private information secure. The pharmacy's team members are good at learning from the mistakes they make during the dispensing process. They put measures in place to reduce the risk of similar errors happening again and therefore help improve people's safety.

Inspector's evidence

The pharmacy had several procedures in place to help manage the risks to the services it offered and help prevent the spread of coronavirus. These included posters on the entrance door and in the retail area, reminding people visiting the pharmacy to wear a face covering as required by law. There were large plastic screens placed at the pharmacy counter which acted as a protective barrier between team members and members of the public. There were markings on the floor of the retail area which helped people socially distance and keep to a one-way flow from their entrance to exit. There was a barrier in front of the pharmacy counter and a sign reminding people to stand behind the barrier until they were called forward by a team member. There were eight seats located around the retail area. Each seat was numbered, and they were approximately two meters away from each other. People who were waiting for their prescriptions to be dispensed were assigned a seat number. The system helped the team manage services efficiently and ensure people were able to appropriately socially distance. The pharmacy's team members were wearing masks throughout the inspection. The main part of the dispensary was of an average size and so it was not always possible for team members to socially distance from each other while they worked.

The pharmacy had a set of standard operating procedures (SOPs). They covered tasks such as dispensing, responsible pharmacist requirements and controlled drug (CD) management. There was an index available to help find an SOP easily. The SOPs were reviewed every two years. There was a sheet at the end of each SOP for team members to sign to confirm they had read and understood its contents. Each team member had read and signed all the SOPs relevant to their roles, within the last two years.

The pharmacists and accuracy checking technician (ACT) spotted near miss errors made by team members during the dispensing process. They informed the dispenser of the error and asked them to rectify the mistake. The dispenser and the pharmacist or ACT made a record of the error on an electronic near miss log and discussed with the dispenser why the error might have happened. The team recorded details such as the type of error, for example, if the error involved medicines of similar names or were manufactured in similar looking packaging. Team members recorded the reasons why a near miss error might have happened. This helped them learn from their mistakes and make specific changes to the way they worked. A pharmacy technician was also the pharmacy's 'patient safety champion'. The technician was responsible for monthly analysis of the near misses to spot any trends or patterns. If any were identified, an action plan was put in place for the team to work towards. The technician had recently spotted that team members were occasionally forgetting to change Latin abbreviations of dose directions into plain English on dispensing labels. For example,'1 b.d.' should be labelled as 'one to be taken twice a day'. The team held a discussion to help raise awareness of the importance of ensuring that all abbreviations were changed on labelling so the direction were clear to

people. The technician explained that the team was improving as fewer such near miss errors were seen in the month following the discussion. The pharmacy kept records of any dispensing errors that had reached people. A form was completed, and a copy was printed and stored in a folder for future reference.
The pharmacy had a concerns and complaints procedure in place. It was clearly outlined for people to see through information leaflets located in the retail area that people could select and take away with them. Any complaints or concerns were required to be raised verbally with a team member. If the matter could not be resolved by the team member, it was escalated to the pharmacy's head office.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice displayed the name and registration number of the RP on duty. Entries in the RP record complied with legal requirements. The pharmacy kept up-to-date and accurate records of private prescriptions. It kept CD registers and records of CDs returned by people to the pharmacy. The CD registers were audited against physical stock every week. The physical stock of two CDs was checked against the running balance in the CD register and they were found to be correct.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bag to avoid a mix up with general waste. The waste was periodically destroyed by a third-party contractor. Team members understood the importance of keeping people's private information secure and they had all completed information governance training as part of their employment induction process. The RP and the ACT had completed level 2 training on safeguarding vulnerable adults and children via the Centre of Pharmacy Postgraduate Education. Other team members had completed internal training and were aware of their responsibilities and when they should escalate any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to provide the pharmacy's services. They manage the workload well and support each other as they work. The pharmacy is good at supporting its team members with a structured training programme. This helps them in improving their knowledge and skills.

Inspector's evidence

At the time of the inspection, the responsible pharmacist (RP) was a locum pharmacist. He was supported by a full-time pharmacy technician and three full-time qualified pharmacy assistants. Team members who were not present during the inspection included a full-time pharmacist, a full-time accuracy checking technician (ACT), who was also the pharmacy manager, and a part-time pharmacy assistant.

Typically, the pharmacy had two resident pharmacists working, one between the hours of 8am and 4pm and the other between 12pm and 8pm. One resident pharmacist had recently left the business and the other was working at a Covid-19 vaccination site. The pharmacist was due to be back working at the pharmacy in four weeks. The pharmacy planned to use locum pharmacists during this time. Team members were highly experienced and explained they were working well despite not working with a regular pharmacist. The team was observed to be working well and were not seen dispensing prescriptions under any significant time pressures. The team members explained the Covid-19 pandemic had been a challenging time, but they felt they had generally coped well and were proud that they had continued to offer an efficient service.

Team members were given the opportunity to train during their working hours to improve their knowledge and skills. They were provided with a structured training programme and protected training time which was on average, approximately one hour per month. They could train in the pharmacy office or consultation room so they would not be distracted. Team members could choose healthcare related topics to learn about or often they were provided with training material to work through. For example, the team had been recently asked to work through a training pack about the role of Boots through the Covid-19 pandemic. A team member explained that she had recently completed training on the Discharge Medicines Service which helped her understand the service better. Team members often had to complete short quizzes after completing their training to assess their understanding.

The pharmacy had a whistleblowing policy in place so the team members could raise and escalate a concern anonymously. And the policy was displayed in the pharmacy staff area. The team had been set targets to achieve, for example, NHS prescription items and services. The team explained that the targets were realistic, and they were consistently achieving them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure and well maintained. It has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, highly professional in appearance and well maintained. The team cleaned the pharmacy regularly throughout the working day to reduce the risk of spreading infection. They paid attention to areas of the pharmacy that were touched regularly such as benches and door handles. The pharmacy dispensary was kept tidy and well organised throughout the inspection. Floor spaces were kept clear to prevent the risk of a trip or a fall. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was large enough for people to appropriately socially distance from each other when in use.

The pharmacy had a clean sink in the dispensary that was used for the preparation of medicines. There was a toilet with a sink and a sink in the staff area which provided hot and cold water and other handwashing facilities. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages these well. And it uses technology to provide its dispensing services safely and effectively. It mostly stores and manages its medicines correctly.

Inspector's evidence

People had level access into the pharmacy via two entrances. One from the street and one from the adjoining health centre. The pharmacy advertised its services and opening hours in the main window. There were seats available in the retail area for people to use while they waited for their prescriptions to be dispensed. Large-print labels were provided on request to help people with a visual impairment. Team members had access to the internet which they used to signpost people requiring services that the pharmacy did not offer. The used written communication to help people with a visual impairment, and there was a hearing loop available. There was a 'local health zone' in the retail area. The zone displayed written information on healthcare topics and there were healthcare related leaflets that people could take away with them. At the time of the inspection, the zone displayed information on encouraging people to adopt healthier eating habits.

Team members were using various laminated cards to use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. 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. There were separate dispensing and checking areas of the dispensary. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person and one was kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. The delivery driver left the medicines on the person's doorstep before moving away and waiting to watch them pick up the medicines. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They demonstrated the advice they would give in a hypothetical situation and there was printed information available in the dispensary to give to people to take away with them and help them manage the risks of taking valproate.

Most of the prescriptions received by the pharmacy were electronic prescriptions. Many of these prescriptions were dispensed a central hub. This was to help reduce the dispensing workload pressure on the team and give them more time to provide other services to people. The pharmacy generally sent prescriptions that were non-urgent to the central hub. More urgent prescriptions such as those for antibiotics or for medicines that needed storing in a fridge, were dispensed on the premises. Data from prescriptions that were to be dispensed at the central hub were entered onto an electronic system by a team member. The information was then checked to ensure it was accurate by the RP. The RP clinically checked each prescription and signed them once this process was complete. Prescriptions that had been entered onto the system and had been clinically checked were stored in a separate, marked basket. It took around two to three days for the dispensed medicines to arrive at the pharmacy after the prescription had been submitted to the central hub. The team had the ability to override the system

and manually dispense any prescriptions that had already been sent to the hub. For example, team members explained they could do this if a person decided they needed their medicines sooner than they expected. All bags containing dispensed medicines were sealed with a patient address label that contained a printed barcode. The barcodes were scanned using a handheld device and the bags were stored in a marked drawer. When people presented to collect their medicines, the team use the handheld device to find out in which drawer a person's medicines were stored. Team members explained that this was a relatively new system that had made them more efficient and helped reduce the time they were taking in finding people's dispensed medicines. The team was also obtaining mobile phone numbers from people so they could be alerted by text message that their medicines were ready to collect. Team members explained that the system had reduced the number of times people presented at the pharmacy before their medicines were ready to collect.

Pharmacy (P) medicines were stored behind the pharmacy counter and so people were not able to self-select them. Prescription only medicines were kept in restricted areas of the premises and they were stored tidily on shelves and in drawers. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The CD cabinets were well organised and out-of-date and patient returned CDs were appropriately segregated. The pharmacy had two medical grade fridges. The team used both to store medicines in that required cold storage. The contents of the fridges were well organised, and the team monitored and recorded the minimum and maximum temperature ranges of both fridges each day. The records seen were within acceptable ranges.

The pharmacy had a process to check the expiry dates of its medicines every three months. The team was up to date with the process. No out-of-date medicines were found after a random check of around 20 randomly selected medicines. The pharmacy attached stickers to medicines to highlight them if they were expiring in the next three months. The date of opening was recorded on medicines that had a short shelf life once they had been opened. During the inspection of the pharmacy's medicines, the inspector found three plain white cardboard boxes which contained medicines that had been removed from their original packaging. All three were labelled but they didn't display the batch number or expiry dates of the medicines. The risks were discussed with the team and the medicines were removed immediately for disposal. The team gave assurances that the risks would be discussed with the pharmacy manager as soon as possible. The pharmacy received drug alerts and recalls. It quarantined any affected stock and a record of the action taken was retained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. Medicines waiting to be collected were stored in a way that prevented people's confidential information being seen by members of the public. Computer screens were positioned to ensure confidential information wasn't seen by people. 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. It had a wireless card terminal for contactless transactions and reduce the use of cash. Team members had access to personal protective equipment including face masks, visors, aprons and gloves.

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.