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: 25/01/2024

Pharmacy context

This is a community pharmacy in the town of Barrow-in-Furness, Cumbria. The pharmacy is adjacent to 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. It sends some of its prescriptions to be assembled at another pharmacy within the company, known as a central hub.

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	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 so help improve people's safety.
		1.4	Good practice	The pharmacy proactively encourages feedback from people who use its services. And it uses this feedback to improve the quality of these services.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members with a structured training programme. This helps them in improving their knowledge and skills and ensures they are ready to provide new services safely.
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 the risks with its services and provides them safely and efficiently. It keeps people's sensitive information secure, and team members are well equipped to help safeguard vulnerable adults and children. 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 so help improve people's safety. The pharmacy proactively encourages feedback from people who use its services. And it uses this feedback to improve the quality of these services.

Inspector's evidence

The pharmacy had a set of electronic and written standard operating procedures (SOPs). They covered tasks such as dispensing, responsible pharmacist requirements and controlled drug (CD) management. 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, but this sheet had not been completed for each SOP. Each team member confirmed they had read and signed all the SOPs relevant to their roles, within the last two years. Team members were required to complete a short assessment following the completion of each SOP. The assessment was used to confirm team members correctly understood the SOP and knew how to follow it.

The responsible pharmacist (RP) spotted errors made and identified by team members during the dispensing process, known as near misses. They informed the dispenser of the error and asked them to rectify the mistake. The dispenser made a record of the error on an electronic near miss log and discussed with the pharmacist 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 team member was appointed the pharmacy's 'patient safety champion'. The team member was responsible for monthly analysis of the near misses to identify any trends or patterns. If any were identified, an action plan was put in place for the team to work towards. The pharmacy used a dispensing software system which required team members to scan the barcode of medicines during the dispensing process. If the incorrect medicine was selected, the software displayed a warning highlighting the error. Team members explained the use of this software had significantly reduced the number of near miss errors. The RP explained the most common type of near miss error were quantity errors. To reduce the number of quantity errors, team members were highlighting the written quantity on prescriptions if it was an uncommon quantity. 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. Additionally, team members encouraged people to complete an online feedback questionnaire. They provided people with leaflets with a QR code that people could use to access the questionnaire. The pharmacy's manager had oversight of each completed questionnaire and any comments that people had made about the service they had received. A sample seen indicated most people received a good,

efficient service from the pharmacy. The manager highlighted a comment made by a person who explained they were dissatisfied with the level of privacy they received when discussing their health with a team member. In response to the negative feedback, the team had made sure they asked people if they felt more comfortable using the pharmacy's consultation room to talk about their health.

The pharmacy had up-to-date professional indemnity insurance. The 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 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 a CD was checked against the running balance in the CD register and they were found to be correct. The pharmacy kept complete records of supplies of special medicines.

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 being mixed 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 pharmacy's manager had completed 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. The pharmacy held the contact details of various local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs team members who have the appropriate qualifications and skills to operate the pharmacy safely. It reviews staffing levels in response to changes in the pharmacy's workload. And it makes appropriate changes to ensure the pharmacy continues to deliver its services effectively and efficiently. The pharmacy is good at supporting its team members with a structured training programme. This helps them in improving their knowledge and skills and ensures they are ready to provide new services safely.

Inspector's evidence

At the time of the inspection, the RP was the pharmacy's regular full-time pharmacist. The RP was supported by a full-time pharmacy technician, two full-time qualified pharmacy assistants and one trainee pharmacy assistant. Team members who were not present during the inspection included three part-time delivery drivers and one part-time qualified pharmacy technician. The pharmacy technician present during the inspection was also the pharmacy's manager. The pharmacy's workload had increased significantly in recent months. It was dispensing around 50% more NHS prescription items. The pharmacy's management team had assessed its staffing profile and concluded the pharmacy would need to employ more team members to manage the increase in workload safely and efficiently. The pharmacy was expecting four team members to join the team in the next few weeks. The pharmacy had employed an accuracy checking technician (ACT), but they had left the business several months ago and not been replaced. The manager explained there was significant pressure on the RP to complete accuracy checks of medicines. The manager was currently completing training to be accredited as an ACT.

Team members were given the opportunity to complete learning 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 complete training 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 for the newly NHS commissioned, Pharmacy First service. Team members had completed a training day about the service. Team members completed short quizzes after 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 premises are suitable for the services provided and the pharmacy maintains them to a high standard. It has a private consultation room where people can have confidential conversations with a pharmacy team member.

Inspector's evidence

The pharmacy was clean, highly professional in appearance and well maintained. The dispensary was tidy and well organised with designated areas for team members to dispense medicines and for the RP to complete final checks of prescriptions. Floor spaces were kept clear to prevent the risk of a trip or a fall.

The pharmacy had two consultation rooms for people to have private consultations with team members. However, due to the recent increase in the pharmacy's workload, one of the rooms was in the process of being converted into an additional dispensary space.

The pharmacy had a clean sink in the dispensary that was used for the preparation of medicines. There were sinks in both the toilet and 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 offers a range of services which are easily accessible to people. It manages these services well. The pharmacy's team members follow robust process to ensure the pharmacy stores and manages its medicines correctly. And this ensures medicines are fit for purpose.

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. The pharmacy had a functioning hearing loop, and team members knew how to operate it.

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 keep prescriptions and medicines together which reduced the risk of them being mixed up. There were separate dispensing and checking areas in 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. 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 pharmacy. This helped to 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 pharmacy. 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 pharmacy was 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 pharmacy. 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 used the handheld device to locate the drawer with the person's medicines. Team members explained the system had made them more efficient and helped reduce the time they were taking in finding people's dispensed medicines. The team obtained mobile phone numbers from people so they could be alerted by text message that their medicines were ready to collect. This helped to reduce 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. 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. 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 appropriate equipment and facilities to safely manage its services. The equipment is well maintained to ensure it is fit for purpose.

Inspector's evidence

Team members had access to up-to-date reference sources including access to electronic copies of the British National Formulary (BNF) and BNF for children. The pharmacy used a range of CE marked measuring cylinders. There was a suitable, electronic blood pressure monitor to support the team in taking blood pressure measurements. The monitor was scheduled to be replaced each year. The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It positioned computer screens to ensure people couldn't 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.