General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Herrington Medical Centre Pharm., Philadelphia Lane, Herrington Burn, HOUGHTON LE SPRING, Tyne and Wear, DH4 4LE

Pharmacy reference: 1037495

Type of pharmacy: Community

Date of inspection: 11/09/2024

Pharmacy context

This is a community pharmacy adjacent to a medical centre in the village of Herrington. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It delivers medicines for some people to their homes and supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The pharmacy team also provides the NHS Pharmacy First service.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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 not all met	1.1	Standard not met	The pharmacy doesn’t identify and manage all the risks with its services. And this has been seen in previous inspections. Its team members don't follow key procedures, the most significant of these is how they manage near misses and dispensing incidents.
		1.2	Standard not met	Pharmacy team members do not routinely record, reflect on, or analyse their mistakes. And they do not make changes to their ways of working to reduce the risk of further mistakes. They do not consider errors that occur in all parts of the dispensing process that are not mitigated by the robotic dispensing technology installed.
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 not all met**

Summary findings

The pharmacy does not adequately identify and manage all the risks associated with its services. The pharmacy has written procedures for most of its services. But its team members don't follow key procedures to ensure the pharmacy provides its services safely and effectively. The pharmacy doesn't record or reflect on learning from the mistakes team members make. And it doesn't make changes to ways of working to help reduce the risk of a similar mistake happening again. The pharmacy keeps records required by law. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information.

Inspector's evidence

The pharmacy had not met all standards on three previous inspections with all relating in some way to the pharmacy's procedures, and often also the recording of and learning from mistakes made during dispensing. The pharmacy had implemented some standard operating procedures (SOPs) following previous inspections such as for the 'assembly and labelling of prescriptions' which was seen to be reflective of their current practice. And they had SOPs for Responsible Pharmacist (RP) regulations and controlled drug (CD) management. But the pharmacy team was seen to not be following other key standard operating procedures. This included the SOP related to dealing with errors and near misses. And as highlighted from previous inspections there was no policy or procedure for safeguarding vulnerable people. The pharmacy did have a procedure for the automated dispensing machine the pharmacy used to dispense a large proportion of its items. However, this was mainly an operational guide and this procedure did not acknowledge the risks mitigated by and not mitigated using this technology when dispensing.

Most of the procedures were signed by all members of the pharmacy team to indicate they had read and agreed with them. For example, there was a 'Dealing with errors and near misses' procedure. During the inspection, team members verbally recalled some recent examples of near miss errors where labels had been transferred to the incorrect medicine or where the wording of directions on a label had needed to be amended. Two dispensing incidents had been recorded in the five months since the previous inspection. And the information recorded on the pharmacy error log was minimal, with no reference to any resulting learning from these incidents and team members could not describe any learning or actions taken. This was not in line with SOP which had been signed by most team members months earlier.

A dispensing error had occurred in the recent months prior to the inspection. This was one of the two recorded incidents in the pharmacy's error log. The RP demonstrated a report that had been made on the national reporting tool. The report contained all the factual information of the incident. However, the report did not contain a reason why this happened or mention any learning that has been taken forward from the incident. And the pharmacy team could not give any examples of modifications to practice made as a result of this or other such incidents.

The team reported the automated dispensing machine used by the pharmacy reduced the risk of selection errors, for medicines that were dispensed in this way. However, this did not protect against all types of errors and did not include medicines dispensed manually, such as those stored in the fridge, such as insulins, or CD cabinet. There was a lack of insight of the importance of learning from errors,

made during dispensing, which meant that there was risk that similar errors could continue to occur.

The pharmacy had a policy for dealing with complaints. The team aimed to resolve any complaints or concerns informally. If they were unable to resolve the complaint, they escalated it to the superintendent pharmacist (SI) who worked regularly at the pharmacy as the RP. The pharmacy had current professional indemnity insurance. The Responsible Pharmacist had their RP notice on display which meant people could see details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP. And they knew what their own responsibilities were based on their role within the team.

A sample of RP records checked during the inspection were compliant. The pharmacy kept paper-based records of the private prescriptions it dispensed. A sample of these checked during the inspection showed that the quantity supplied by the pharmacy was not always recorded. The importance of maintaining accurate records was discussed during the inspection. Team members checked the physical stock levels of CDs against the balances recorded in the CD register on each dispensing and on receipt of the medicine. And they completed regular additional audits of CDs less commonly dispensed. Random balance checks against the quantity of stock during the inspection were correct. The pharmacy kept a register of CDs returned by people, and there were records of these returns being destroyed.

The pharmacy team was aware of the need to keep people's personal information safe. And team members kept confidential waste and general waste separate. A third-party company collected the confidential waste regularly for destruction. The pharmacy did not have a written safeguarding policy, and this had been highlighted in previous inspections. Some pharmacy team members had previously completed some learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns. They knew to discuss any concerns with the RP, and where to access contact details for relevant local agencies, if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to provide its services. Team members work together and within the scope of their competence. And they have opportunities to complete ongoing training so they can develop their knowledge. Pharmacy team members know how to raise concerns, if needed.

Inspector's evidence

At the time of the inspection, the RP was the regular pharmacist and superintendent (SI) of the pharmacy. They were supported by a team that consisted of a qualified pharmacy technician and three trainee dispensers. Other team members who were not present during the inspection were another qualified technician and a regular pharmacist who worked at the pharmacy part-time. Planned leave requests were managed so that only one team member was absent at a time. And the SI advised that where possible they would manage workload in advance of the planned absence. Part-time staff members helped cover absences by working additional hours. The team were observed to be calmly managing the workload throughout the inspection even during a busy period when the pharmacy re-opened after closing at lunchtime. Team members had all completed accredited training or were enrolled on an accredited qualification training course for their role. All team members enrolled on an accredited training course received regular protected learning time during quiet periods. And all team members had access to additional learning materials relevant to their roles which was provided by the SI. Although several members of the team were in training positions, the competence and skill mix of the team appeared appropriate for the nature of the business and the services provided.

A newly employed delivery driver worked two days a week for the pharmacy. They had received some training during their induction but had not been enrolled on a recognised training course. The need to enrol the driver on a recognised training course by the end of their induction period was highlighted during the inspection. Pharmacy team members asked appropriate questions when selling medicines over the counter and referred to the RP at appropriate times. They were knowledgeable about the potential for certain medicines to be misused. And they were confident challenging requests for over-the-counter medicines that they deemed inappropriate.

Pharmacy team members explained that the culture of the team was to be open and honest with each other. And they gave examples of how this approach has helped them work better as a team. But there was no culture to learn from near miss errors and dispensing incidents, and errors were not discussed as a team to learn from them. Team members felt comfortable raising concerns with the SI, if necessary. And they had regular informal meetings where there was the opportunity to raise such concerns. The pharmacy was not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. And the pharmacy has a consultation room to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was in a good-sized premises. The main areas were the retail area and dispensary. The pharmacy's automated dispensing machine was accessed and operated from a computer terminal at the back of the dispensary. There were more areas off to the side of the dispensary used for the preparation of multi-compartment compliance packs, storage, and staff facilities. The pharmacy had an overall appearance which was suitably professional. The retail area of the pharmacy was open plan and had a central fixed couch for people to sit when waiting. There were lockable doors to prevent unauthorised access to the staff-only areas of the pharmacy. The dispensary workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for assembled medicines and medical devices. Walkways were generally kept clear to minimise trip hazards. The RP used a separate bench to complete their final checks of prescriptions. This overlooked the medicines counter, and this layout supported the supervision of medicines sales and queries. The lighting and temperature were suitable to work in and to provide healthcare services. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There was staff and toilet facilities that were hygienic.

The pharmacy had a private consultation room which was used by team members to deliver some services and have private conversations with people. It was suitably constructed for the purpose it served. The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks daily.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources its medicines from recognised suppliers. And it stores and manages them appropriately. Pharmacy team members complete regular checks to ensure medicines are suitable for supply. Team members manage the delivery of services effectively. And they take opportunities to provide people with advice on higher-risk medications so they can take these medicines safely.

Inspector's evidence

The pharmacy had level access via its two entrances, from the car park and from within the GP surgery. The pharmacy displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information posters for people to read. The pharmacy provided a medicines delivery service. The team applied a flag on the pharmacy's PMR system to the records of those people who required delivery. This made it clear to team members when dispensing prescriptions which ones should be treated as deliveries. The pharmacy stored assembled bags of medicines for delivery separate from others. And the team kept paper records of completed deliveries so it could answer queries relating to them. The driver returned any failed deliveries back to the pharmacy on the same day.

The pharmacy had an automated dispensing machine that the team used to help select medicines to be dispensed. Team members had received training from the manufacturer of the dispensing machine. Prescriptions were downloaded electronically where possible and then processed via the PMR system, which created labels and communicated with the dispensing machine. The information inputted in to the PMR system was used by the dispensing machine to select the correct medicines. These were released from the machine for team members to apply the dispensing labels. When filling the machine, the team scanned the barcodes on medicines before placing on to a loading belt. And the barcode enabled the machine to identify the medicine. Team members scanned 2D barcodes where possible, as this additionally provided the batch number and expiry date of the medicine. The SI and pharmacy team members clearly explained how they used the automated dispensing machine. And how it supported them to dispense prescriptions accurately. The dispensing machine had an emergency operation function to allow team members to dispense manually as a contingency in case of any system failure. And the pharmacy had a support service available from the manufacturer during their opening hours.

A proportion of the pharmacy's workload involved supplying people's medicines in multi-compartment compliance packs. This helped people better manage their medicines. Team members ordered people's prescriptions in advance of the compliance pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any related queries. The pharmacy used a record for each person that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs dispensed at the pharmacy. A significant amount of the multi-compartment compliance packs were outsourced to another local pharmacy to prepare and they were returned to the pharmacy for delivery or for people to collect. A team member explained the pharmacy had collected written consent from people to have their packs dispensed by another pharmacy and they kept a record of these. These packs made it clear to people which pharmacy had dispensed them and who to contact in case of queries. For the packs assembled at the pharmacy, team members attached backing sheets to the packs that they prepared, so people had written instructions of how to take their medicines. And the packs were annotated with detailed descriptions of medicines in the pack, which allowed people to identify their medicines. People were

provided with patient information leaflets about their medicines with their packs each month, so people had up-to-date information about their medicines.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Pharmacy team members signed dispensing labels during dispensing and checking. This maintained an audit trail of the team members involved in the process. They used stickers to highlight if a prescription contained a fridge item, to ensure correct storage temperatures were maintained.

The RP provided counselling on a range of higher-risk medicines when supplying them to people. They were observed annotating notes on to the copies of prescriptions when completing their final check, if they contained medications that required further advice and counselling. These notes prompted other team members when retrieving the prescription for handout, as well as sharing information with other pharmacists that may be working as RP when the prescription was collected. The pharmacy team showed a good understanding of the requirements for dispensing valproate for people who may become pregnant and of the recent safety alert updates involving other medicines with similar risks. The team dispensed prescriptions for these medicines in the manufacturer's original packs. And it had patient cards and stickers available to give to people if needed.

When the pharmacy could not entirely fulfil the complete quantity required on a prescription, team members created an electronic record of what was owed on the PMR system. And they gave people a note detailing what was owed. This meant the team had a record of what was outstanding to people and what stock was needed. The team checked outstanding owings daily and were managing these well. The pharmacy had a procedure for checking expiry dates of medicines. It used the automated dispensing machine to monitor for short-dated and expired medicines. The machine determined the medicines expiry date via the 2D barcode on each pack. If the pack did not have a barcode, the expiry date was entered into the machine's system manually when the team placed the medicine in the machine. Each month, pharmacy team members used the system's data to retrieve any medicines expiring that month for disposal. Team members also checked other sections of the dispensary and marked any medicines that were expiring soon or removed any that had already expired. Evidence was seen of medicines highlighted due to their expiry date approaching or because the shelf life was reduced after being opened. The pharmacy kept unwanted medicines returned by people in pharmaceutical waste containers, while awaiting collection for disposal.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. The pharmacy held medicines requiring cold storage in medical fridges equipped with thermometers. Team members monitored and recorded the temperatures of the fridges regularly. These records showed cold-chain medicines were stored at appropriate temperatures. A check of the thermometer during the inspection showed temperatures were within the permitted range. The pharmacy held its CDs in secure cabinets. It received drug safety alerts and manufacturer's recalls via email and had records of alerts received and any actions taken in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF) and the BNF for children. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of clean, well-maintained tablet counters. The automated dispensing machine had planned regular servicing by the external provider. And engineer support was available via telephone. The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.