General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Haydon Bridge Pharmacy Ltd, 5 Church Street, Haydon Bridge, HEXHAM, Northumberland, NE47 6JG

Pharmacy reference: 1095023

Type of pharmacy: Community

Date of inspection: 26/05/2022

Pharmacy context

This is a community pharmacy in the village of Heydon Bridge, Hexham. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. And it delivers medicines for some people to their homes. The pharmacy supplies some people living in their own homes and local care homes with medicines in multi-compartment compliance packs. This helps them take their medicines. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 adequately identify and manage all risks associated with the services it provides. This includes the risks relating to the way it manages the area where team members dispense medicines. And how it manages and stores some medicines. The team doesn't follow some key written procedures to ensure services are always safely provided.
		1.6	Standard not met	The pharmacy does not keep adequate or up-to-date records of its controlled drugs.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	Not all areas of the pharmacy are in a suitable condition for the team and the services it provides. Areas where team members dispense are untidy and excessively cluttered. This increases risk of mistakes being made and creates a significant tripping hazard.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn’t adequately store or appropriately manage all its medicines. It doesn't receive and manage its medicines from wholesalers in the most appropriate way. And it doesn't have robust processes to identify out-of-date medicines. It stores some medicines outside of their original packaging, without proper labelling. And so, the pharmacy cannot make the necessary checks to ensure these medicines are suitable to supply to people.
5. Equipment and facilities	Standards not all met	5.2	Standard not met	The pharmacy doesn't always use its facilities in a way that protects people's private information.

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't adequately identify and manage all risks associated with the services it provides. This includes not making sure the area where team members dispense medicines is always safe and suitable. And not adequately managing storage of its medicines. The pharmacy doesn’t keep all the records it must by law up to date, creating significant risk. Team members follow a process to record mistakes made during the dispensing process. And they show some learning from the mistakes to reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. It had some procedures in place to help manage the risks and to help prevent the spread of coronavirus. These included notices reminding people visiting the pharmacy to wear a face covering. All team members were wearing face coverings throughout the inspection. There was a plastic screen at the pharmacy counter to act as a protective barrier between team members and people visiting the pharmacy. The pharmacy's team members socially distanced from each other when they could. The pharmacy had hand sanitiser placed in areas around the retail area and the dispensary to promote good hand hygiene.

The pharmacy had a set of written standard operating procedures (SOPs). The SOPs covered tasks such as dispensing and controlled drug (CD) management. They were reviewed in 2018. The team members signed record sheets to show they had read and understood those SOPs that were relevant to their role. There was an index which helped team members easily find a specific SOP. The team didn't follow the procedures in some key SOPs, including CD management. It didn't manage the risks of working in a cluttered environment and it didn't identify the risks around the way it stored people's medicines awaiting collection.

The pharmacy had a process in place for team members to record and report mistakes spotted during the dispensing process. These mistakes were known as near miss errors. When a team member spotted a near miss error, the team member informed the dispenser of the error and asked them to rectify the mistake. The pharmacy had two near miss logs kept in each dispensary into which team members recorded details of any near miss errors made. Team members were required to transfer the details of each entry onto an online reporting system. But they didn’t always do this. The electronic system helped the team analyse the near miss errors for any trends or patterns. And so, the team may have missed the opportunity to make specific changes to the way it worked to improve patient safety. There were some examples of learning from near miss errors, as team members explained they were aware of the increased risk of errors with medicines that had similar names. For example, sildenafil and sertraline. Dispensing incidents were immediately brought to the attention of the superintendent pharmacist (SI). The SI assessed the severity of the incident and took steps to rectify them. The pharmacy had an informal concerns and complaints procedure. Any complaints or concerns were verbally raised with a team member. If the team member could not resolve the complaint, it was escalated to the SI.

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. The pharmacy correctly completed the RP register and kept it up to date. Team members knew which tasks they could and could not do in the

absence of the RP. CD records were incomplete and not up to date, creating significant risk. The pharmacy segregated CDs that had been returned by people for destruction. But there were no records seen of receipt or destruction of these medicines.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. But it didn't always use the facilities it had when considering storage of other aspects of people's confidential information. This resulted in some people's details being accessible to others. It separated confidential waste to avoid a mix up with general waste. The team periodically destroyed confidential waste. The team members understood the importance of ensuring they didn't discuss people's private information in areas of the pharmacy where they could be overheard by others.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the skills to suitably provide the pharmacy's services. Team members work well to support each other and manage the dispensing workload. But the pharmacy does not suitably share all tasks such as record keeping, making sure they are up to date.

Inspector's evidence

At the time of the inspection, the SI was the RP. During the inspection the SI was supported by a full-time resident second pharmacist, two full-time trainee pharmacy technicians, two full-time qualified accuracy checking technicians (ACTs), three full-time trainee pharmacy assistants, one full-time qualified pharmacy technician and two part-time qualified pharmacy assistants. The pharmacy also employed a delivery driver. One of the ACTs was also the pharmacy's manager and had additional administrative responsibilities. There were two dispensing teams. One team worked on the ground-floor and managed the retail area and more urgent prescriptions. The other team worked in the first-floor dispensary and managed the process of dispensing medicines to people in care homes and to people receiving multi-compartment compliance packs. The pharmacy managed a busy workload. During the inspection the team worked well and was not dispensing medicines under any significant time pressures. Team members supported each other to help complete the dispensing workload but did not keep the working environment tidy and so this created risk. Tasks, such as record keeping, were not shared or delegated by the SI which led to pressures and key tasks not being completed.

Team members discussed various topics during team meetings including daily tasks and staff rotas. The meetings were held on an ad-hoc basis. The pharmacy didn't have a structured training programme in place for its team members. They trained in their own time to update their knowledge and skills. The team was not set any performance related targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not keep all areas in a suitable condition both for the team and the services it provides. The area where team members dispense is untidy and excessively cluttered. This creates an increased risk of the team making mistakes. And presents a tripping hazard for team members. The pharmacy has a suitable consultation room that people can use to have private conversations with team members.

Inspector's evidence

The pharmacy had two main dispensing areas. One on the ground floor and one on the first floor. The ground floor dispensary was relatively small and many team members were present in the area at the same time. This made moving round each other difficult and they were not able to appropriately socially distance to prevent the spread of coronavirus during the COVID-19 pandemic. The pharmacy had ample bench space to complete dispensing activities. But during the inspection the benches were cluttered with baskets of prescriptions and medicines awaiting a final check, packs of medicines that had not been returned to their original place on shelves and miscellaneous paperwork. This increased the risk of mistakes being made during the dispensing process. Several baskets and tote boxes containing medicines returned by people for disposal were cluttering the floor space. This didn't fit in with the professional and hygienic image of a pharmacy. And it created a trip hazard for team members. The pharmacy had a larger first-floor dispensary, but it was kept in a similar, cluttered manner to the ground floor dispensary. The first floor had an office and a room used for storing medicines and other miscellaneous items. The room was full, including a significant amount of pateint returned medicines and it was difficult to safely move around in. The SI explained the pharmacy had significant volumes of patient returned medicines that had not been promptly arranged to be removed.

The pharmacy had a signposted consultation room to help people have private conversations with team members. The room was professional, sound-proofed, contained two seats and was large enough for two people to appropriately socially distance from each other. The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy doesn’t always adequately store and manage its medicines appropriately. It doesn’t receive and manage its medicines from wholesalers in the most appropriate way. And it doesn’t have robust processes to identify out-of-date medicines on its shelves. The pharmacy adequately helps people access its services. And it satisfactorily manages the delivery of these services.

Inspector's evidence

People had level access into the pharmacy through the main entrance door. The pharmacy advertised some of its services on a front window. The pharmacy held a range of healthcare related leaflets for people to select and take away with them. The team members had access to the internet which they used to signpost people requiring services that the pharmacy did not offer.

Team members used various stickers to attach to bags containing people’s dispensed medicines. They used these 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. However, throughout the inspection, baskets were stacked on top of each other. And so, there was a risk of them being knocked over and peoples' medicines being mixed. The pharmacy offered a delivery service to people. It kept comprehensive records of the delivery process so an audit trail was in place of completed deliveries and occasions where the delivery process could not be completed. For example, if a person was not at home.

The pharmacy supplied medicines in multi-compartment compliance packs to several people living in their own homes and to 21 local care homes. A small percentage of the packs were assembled using automation. The team dispensed the packs in the first-floor dispensary. This helped team members dispense the packs away from the retail area to reduce the risk of distractions. Team members used master sheets which contained a list of the person's current medication and dose times. Team members checked prescriptions against the master sheets before the dispensing process started to make sure they were accurate. Team members discussed any queries with the relevant prescriber. They recorded details of any changes such as dosage increases or decreases on the person's master sheet and their electronic record. The team kept records of when it completed certain stages of the dispensing process. For example, when prescriptions had been received from the relevant prescriber. This helped the team track the progress of the process. The pharmacy supplied the packs with descriptions of the medicines to help people identify them. For example, 'orange, round, tablet'. But it didn’t supply the packs with patient information leaflets for each medicine. And so, people may not receive the full information about their medicines.

The pharmacy stored pharmacy (P) medicines behind the pharmacy counter. The pharmacy had a process for the team to check the expiry dates of its medicines every three months. Team members signed a sheet to show which medicines they had checked and when. So, an audit trail was in place. Team members highlighted the expiry dates of medicines using a marker pen. They did this if the medicine was due to expire within the next six months. The inspector found 4 out-of-date medicines

after a check of around 20 randomly selected medicines. The out-of-date medicines were not identifiable as short-dated. Team members were not observed to be checking the expiry dates of medicines during their dispensing process. The team recorded the date of opening on some medicines that had a short shelf life. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It used five fridges to store medicines that needed cold storage. The team kept daily records of the fridge's minimum and maximum temperatures. A sample of the records showed the fridge was operating within the correct temperature ranges.

The pharmacy had enough shelves to store medicines. But many of these shelves, in both dispensary areas, were full and untidy. There were many packs of medicines stored on the floor and on benches. In the first-floor dispensary, there were approximately 10 alphabetically labelled, large tote boxes which held only split packs of medicines. The medicines were not organised and were placed randomly on top of each other. Team members were asked to dispense these split packs of medicines first before using full packs of medicines. Team members explained they didn't like the system and had discussed ways to improve but had not had the time to put any actions into place. The team accepted the way the pharmacy stored medicines increased the risk of mistakes being made. The pharmacy also stored many tablets and capsules in blisters outside of their original packs. Some of these blisters had been cut and so they didn't display the medicines' expiry date and batch number. This meant there was a risk out-of-date medicines could be dispensed to people. And the team may not be able to identify medicines using their batch numbers, if they were subject to a recall. On the day of the inspection, the pharmacy had received an order of medicines from a wholesaler. The order had been placed on the floor of the retail area. This was because of the excessive clutter in the dispensary. Team members were seen unpacking the medicines in the retail area and then putting them away in the dispensary. For much of the inspection, prescription only medicines, such as omeprazole and atorvastatin, remained stored in open tote boxes in the retail area close to where people sat on chairs while they wait for their medicines to be dispensed. And so, there was a significant risk the medicines could be accessed by unauthorised people. The team was made aware of the risk and worked to remove the medicines from the retail area.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy does not always use its facilities appropriately to protect people's confidentiality. It has the equipment it needs to provide its services.

Inspector's evidence

The pharmacy used a range of CE quality marked measuring cylinders. It used automation to pack medicines into multi-compartment compliance packs. The machine was regularly serviced, and the team had the contact details of a maintenance engineer who could be contacted if there was an immediate problem.

The pharmacy suitably 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. Team members had access to personal protective equipment including face masks 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.