

Registered pharmacy inspection report

Pharmacy Name: Healing Pharmacy, 101-103 Station Road, Healing, GRIMSBY, South Humberside, DN41 7RB

Pharmacy reference: 1113809

Type of pharmacy: Community

Date of inspection: 21/01/2020

Pharmacy context

This community pharmacy is in Healing, a village between Immingham and Grimsby in North East Lincolnshire. The pharmacy forms part of the village shop. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies some people with their medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to a small care home. And it delivers medicines to people's homes.

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	N/A	N/A	N/A
2. Staff	Standards met	2.5	Good practice	The pharmacy promotes how its team members can provide feedback. This feedback is listened to and used to inform changes to services and to the layout of the pharmacy.
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 the risks associated with its services. It keeps people's private information secure and it responds to feedback about its services appropriately. Pharmacy team members understand how to recognise, and report concerns to help protect the wellbeing of vulnerable people. They act openly and honestly by sharing information when mistakes happen during the dispensing process. And they act to reduce risk following these types of mistakes. The pharmacy generally keeps all records it must by law up to date. But some minor gaps in some of these records may make it more difficult for the pharmacy to manage a query should one arise.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). Most SOPs had been implemented in 2012 and had been reviewed at two yearly intervals by the pharmacist manager. The manager was one of the company's directors. SOPs covered controlled drug (CD) management, responsible pharmacist (RP) requirements and pharmacy services. They included the roles and responsibilities of pharmacy staff. And pharmacy team members had signed those relating to their roles. They were observed working in accordance with dispensing SOPs during the inspection. And a dispenser explained what tasks could and couldn't be completed if the RP took absence from the premises.

Workflow in the dispensary was managed well. The dispensary was set back from the medicine counter and village shop. This helped provide a protected space for managing dispensing tasks. The majority of work came through the Electronic Prescription Service (EPS). This provided team members with the opportunity to complete dispensing tasks without the increased pressure caused by high volumes of acute work. There was separate space in the dispensary for labelling, assembling and accuracy checking medicines. And a protected area to the side of the dispensary provided suitable space for completing tasks associated with the multi-compartment compliance pack service and care home.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members explained they discussed their mistakes at the time they occurred. And they generally recorded details of their mistakes within the near-miss error log. A pharmacy team member acknowledged that sometimes the opportunity to record a mistake was not taken. This was normally in busier periods where the mistake was managed through the team member reviewing their work and correcting their mistake. Entries in the near-miss error log contained some learning points. But these were quite generic and repetitive. For example, 'double check'. A discussion took place with the dispenser about the advantages of recording contributory factors causing mistakes. The pharmacy had an incident reporting procedure. The RP explained to his knowledge the pharmacy had not needed to record this type of mistake to date. And pharmacy team members demonstrated the checks they applied during the dispensing process which helped to detect a mistake before a medication left the pharmacy.

The pharmacy manager had completed an annual patient safety review in 2019 to help identify trends in mistakes. And pharmacy team members identified how they regularly discussed patient safety and took action to reduce risk. For example warning labels were placed on shelf edges to prompt additional checks during the dispensing process. And the team had separated some 'look-alike and sound-alike' medicines on the dispensary shelves.

The pharmacy had a complaints procedure. But this was not seen to be advertised to people visiting the pharmacy. Pharmacy team members had a sound understanding of how to manage and escalate a concern if required. And they could provide examples of how they listened to feedback from people using the pharmacy. For example, by supplying preferred brands of medication when able to. The pharmacy submitted annual reports to the NHS about its complaints. The most recent report confirmed the pharmacy had managed no complaints associated with the NHS services it provided.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice was updated to reflect the correct details of the RP on duty shortly after the inspection began. Entries in the RP record complied with requirements. The Prescription Only Medicine (POM) register generally complied with legal requirements. Occasional dates were observed to be missing from some entries in the register. The pharmacy held records of emergency supplies electronically. But there was not always a reason recorded when making a supply at the request of a patient. The pharmacy kept records for unlicensed medicines in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA). It maintained running balances in its CD register. It checked balances upon receipt and supply of CDs. But the frequency of full balance checks was sporadic. The last recorded full balance checks in the register were April and September 2019. Physical balance checks of CDs completed during the inspection complied with the balances recorded in the register. The pharmacy kept a patient returned CD register. And pharmacy team members entered returns in the register on the date of receipt.

The pharmacy generally stored people's personal information in staff only areas of the pharmacy. A closed folder with some flu vaccination records inside was found in the unlocked consultation room. The risk of storing information in this way was discussed. And the RP immediately made other arrangements to ensure the folder remained in the dispensary between use. Pharmacy team members demonstrated how their dispensing process kept people's information safe and secure. All team members had completed some learning relating to confidentiality requirements. The pharmacy had submitted its latest NHS Data Security and Protection toolkit as required. Pharmacy team members disposed of confidential waste by using a cross shredder.

The pharmacy had procedures and information relating to safeguarding vulnerable people. Contact information for safeguarding teams was readily available for its team members to refer to. The RP had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). The dispenser had completed some learning on the subject during her apprenticeship. And she explained how team members worked to support vulnerable people. For example, by carrying out local deliveries of medicines to people personally if the delivery driver had finished for the day. The delivery driver explained how he would report a safeguarding concern. And the RP reflected on a concern which he had managed when working at a different pharmacy.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. The pharmacy promotes how its team members can provide feedback. This feedback is listened to and used to inform changes to services and to the layout of the pharmacy. Pharmacy team members engage in conversations relating to managing their work load and patient safety. And they receive some support for ongoing learning at work.

Inspector's evidence

On duty during the inspection was the RP, a qualified dispenser and a delivery driver. The RP was a regular locum pharmacist who worked three days each week at the pharmacy. The pharmacist manager worked two days each week and a regular locum pharmacist worked on Saturday's. The pharmacy also employed another dispenser and another delivery driver. Staffing levels had been low in the months leading up to the inspection. This was due to one dispenser taking planned long-term leave. The RP explained that on one occasion when there was concerns with the staffing levels a member of staff from another pharmacy within the company had provided some support to the team.

The dispenser on duty had recently completed her accredited dispensing course. And she had received protected learning time at work through an apprenticeship. The dispenser explained there was some scope to continue this learning as the level three course had been discussed. She identified how she learnt something new every day and explained she was confident in asking pharmacists questions to support her learning. For example, asking about the indications of medicines. There was no ongoing structured learning for team members. But the pharmacy was taking steps to engage in learning associated with healthy living. Pharmacy team members did not receive a formal appraisal. But they had regular conversations about their learning and development with pharmacists.

The pharmacy did not set specific targets for the services provided. The RP explained how he was able to engage with people visiting the pharmacy and take time to discuss their health and wellbeing with them. The RP regularly spoke with the pharmacy manager to share information. And the re-fit and implementation of the consultation room had taken place following the RP's feedback about the advantages of offering other NHS services such as Medicines Use Reviews (MURs) and flu vaccinations.

The pharmacy team shared information relating to workload management and patient safety informally, through conversation rather than structured meetings. This meant that there may be some missed opportunities to share learning when team members were not on duty. The pharmacy had a whistleblowing policy. And team members explained that the manager was open to suggestions and took these on board. For example, improvements to the way the multi-compartment compliance pack service was managed came about through shared feedback. The dispenser explained her course provider had regularly spoken to her about support at work. And she had a clear understanding of how to raise and escalate a concern if required.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and clean. It was in a good state of repair, having benefitted from a minor refit around a year ago. Pharmacy team members had the authority to use local tradespeople to manage minor maintenance concerns. And they reported any serious maintenance concerns to the owner. Pharmacy team members had access to hand washing facilities onsite. These were equipped with antibacterial handwash and towels. The pharmacy used electric heaters to heat the premises. Lighting throughout the pharmacy was sufficient.

The premises consisted of the medicine counter, dispensary and a small consultation room. The consultation room was cluttered. This was due to the pharmacy accepting winter clothing donations for a local homeless shelter. The RP confirmed the donations were due to be collected. On the day of the inspection the bags of donations did distract from the professional appearance of the room. But the room was accessible. The dispensary was a sufficient size for the level of activity carried out. But it did not have much storage space. This meant the pharmacy held some equipment such as spare bags and bottles in a stock room at the back of the shop. Floor spaces and work benches in the dispensary were free of clutter.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services safely and effectively. And its team members follow these procedures. The pharmacy obtains its medicines from reputable suppliers. And it has systems to ensure it stores and manages its medicines safely and securely. But it doesn't always supply information leaflets with medicines to help people take their medicines safely.

Inspector's evidence

The village shop and post office was accessible from street level. The pharmacy was located to the back of the shop and could be clearly seen from the door. The door to the shop sounded as people entered and a gavel at the medicine counter was also provided for people to use on the counter if team members had not heard the door. The pharmacy displayed details of its opening times. And a leaflet at the medicine counter provided details of some of the pharmacy's services.

The pharmacy had offered the NHS seasonal flu vaccination for the first year. It had a legally valid patient group direction (PGD) to support the RP in delivering the service. And the RP's vaccination training records were available. The RP discussed how popular the service had been with people living in the village. Positive feedback had been received about the service, particularly in terms of its accessibility. The pharmacy had access to an up-to-date minor ailments protocol. And pharmacy team members identified how most people accessing this service had young children with them. The service was becoming more popular with the over 60's.

A dispenser was aware of medicines which would require referral to the pharmacist. The RP explained he would provide verbal counselling about monitoring checks associated with medicines such as warfarin and methotrexate. But the pharmacy team did not record the details of these checks on people's medication records. The pharmacy had information and guidance to support it in managing the supply of valproate and isotretinoin to people in the high-risk group who required a pregnancy prevention plan. The RP confirmed the pharmacy was not currently supplying valproate to any person in the high-risk group. It had valproate warning cards available to issue to people, in accordance with the requirements of the valproate pregnancy prevention programme (PPP).

The pharmacy had a schedule to support team members in managing the supply of medicines in multi-compartment compliance packs. Each person receiving their medicines in this way had a profile sheet in place. And there was an audit trail in place to help identify what stage of the ordering and dispensing process each pack was at. A dispenser explained how changes to medication regimens were checked with surgery teams. But these changes were not always recorded clearly. A sample of assembled packs included full dispensing audit trails. But the pharmacy did not provide descriptions of the medicines inside the packs, to help people recognise them. And it did not routinely supply patient information leaflets for the medicines inside the packs. A discussion took place about the requirement to supply these leaflets, in accordance with the Human Medicines Regulations 2012. The pharmacy did provide descriptions of the medicines inside the packs supplied to the care home. And it supplied the care home with Medicine Administration Record (MAR) sheets. The pharmacy collected prescriptions for interim supplies to the care home. And they sent interim medicines out to the care home on the daily delivery

run.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy had electronic audit trails in place for its prescription collection service. This allowed it to ensure the required medicines were correctly prescribed. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. The audit trail for the prescription delivery service was not robust as people did not routinely sign to confirm they had received their medication. This meant it could be more difficult for the pharmacy to manage a query about a delivery should one arise. A delivery driver explained people signed for CDs and for community nursing prescriptions only. The care home also signed for deliveries.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The pharmacy had yet to take any steps to begin implementing processes to comply with the requirements of the Falsified Medicines Directive (FMD). Both team members on duty explained the pharmacy manager had discussed FMD requirements around a year ago. But any details of how the pharmacy would comply with these was not yet shared with the team. Pharmacy team members were aware of changes to medicine packaging. For example, tamper proof seals. And the RP explained he checked original packaging routinely to ensure the medicine inside was intact and not damaged.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The RP was observed providing counselling to people when they purchased medicines and when he handed out prescriptions. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. Pharmacy team members explained they date checked stock regularly. But they did not always record when they had completed date checking tasks. They did update a list of short-dated medicines which required removing from the shelves before they expired. A random check of dispensary stock found no out-of-date medicines. But it did highlight the need for the pharmacy team to record the opening date on liquid medicines, particularly those with a shortened shelf life once opened.

The pharmacy had a secure cabinet for the storage of its CDs. Medicines inside the cabinets were stored in an orderly manner. Out-of-date CDs were separated from stock. There was a need for the pharmacy to organise an authorised witness to attend to witness the safe destruction of these medicines as they had built up over time. The pharmacy highlighted CD prescriptions to prompt additional safety and security checks during the dispensing process. The pharmacy's fridge was clean and stock inside was stored in an organised manner. Temperature records had some gaps. But temperatures either side of these gaps confirmed that it was operating between two and eight degrees Celsius as required.

The pharmacy received drug alerts and recalls by email from the NHS central alerting system. And the team could demonstrate how these alerts were read and actioned. But it had not completed checks of its consultation room following a recent recall of Emerade autopens. And two pens subject to recall were found in the room. The RP confirmed he would act on the alert. And he explained how he could signpost people to another pharmacy if he was unable to source replacement adrenaline to support the flu vaccination service. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members manage and use equipment in a way which protects people's confidentiality

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy computer was protected from unauthorised access due to the layout of the premises. And passwords and NHS smartcards were used to access people's medication records. The pharmacy held assembled bags of medicines within the dispensary. This protected people's private information on prescriptions and bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets. This meant they could move out of ear shot of the public area when speaking to a person over the telephone. This helped to protect the person's privacy.

The pharmacy had a blood pressure machine in the consultation room. And the RP explained how the machine was used for screening purposes only, upon request. The pharmacy referred people to their GP for further checks if there was any concern with the results. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. And clean counting equipment for tablets and capsules. Its electrical equipment and cables were free from wear and tear. But there was no evidence of equipment being subject to portable appliance checks.

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.