General Pharmaceutical Council

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: 21/03/2023

Pharmacy context

This community pharmacy is to the rear of the village store in Healing a large village near Grimsby. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides some people with their medicines in multi-compartment compliance packs to help them take their medication. And it delivers medicines to several people's homes. The pharmacy changed ownership in February 2023.

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	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 met

Summary findings

The pharmacy mostly identifies and manages the risks associated with its services. It has written procedures that the pharmacy team generally follows. And it completes all the records it needs to by law. Team members mostly protect people's private information correctly and they respond appropriately when errors occur. They discuss what happened and they take action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. The SOPs had been reviewed in June 2020 by the previous owner and were being reviewed by the new owner. Team members had read the SOPs but there was no evidence such as completed signature sheet to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for the team to follow when errors occurred during the dispensing of prescriptions, known as near misses. And it had a separate procedure for managing errors that were identified after the person received their medicines, known as dispensing incidents. The pharmacist asked the team member involved to identify their own near miss error. But the record of the near miss was made by the pharmacist rather than the team member involved. So, they didn't have the opportunity to capture their thoughts about the error and how they'd prevent it from happening again. The pharmacist discussed the near miss errors with all the team and highlighted ones that would be classified as a serious untoward incident if they'd reached the person. Products with similar packaging were highlighted to team members to prompt a double check of the medicine they selected when dispensing. All team members were informed when a dispensing incident occurred, so they were aware of it. And of the actions taken to prevent the error from happening again. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And people left reviews about the pharmacy's services on social media platforms.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The RP notice was incorrect at the start of the inspection but corrected when this was highlighted to the RP. Checks of the balance of the CD registers against the physical stock took place when an entry was made in the register. A check of the balance of all the CD registers against the CD stock held took place on 10 February 2023 when the change of ownership occurred. A random check of the balance of one CD register against the stock held was correct. The pharmacy provided team members with information on how to protect people's confidentiality and private information. And they separated confidential waste for shredding onsite. However, some multi-compartment compliance packs labelled with people's details were stored on open display in the consultation room. Whilst the room was locked when not in use there was a risk that people invited into the room by team members may see other people's private information.

There were no safeguarding procedures for team members to follow but they had a level of training to help them understand their role in protecting vulnerable people. The pharmacist had completed level 2

training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had not had the occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They share ideas and implement new processes to enhance the delivery of pharmacy services. However, they have limited opportunities to complete ongoing training. So, they may miss the chance to further develop their skills and knowledge.

Inspector's evidence

The Superintendent Pharmacist (SI) and the pharmacist owner covered the pharmacy's opening hours. The team consisted of a part-time qualified dispenser, a part-time pharmacy apprentice, a part-time trainee dispenser and a part-time delivery driver. At the time of the inspection the SI and all team members except the qualified dispenser were on duty. They worked well together especially in the confines of the small dispensary and ensured people presenting at the pharmacy were not kept waiting.

Trainees had protected time at work to complete their training and were supported by the pharmacists and qualified dispenser. Additional training was limited to information provided by the SI and the pharmacist owner. Team members received informal feedback on their performance. But they didn't have the opportunity to formally reflect on their performance and identify opportunities to progress and develop their skills.

The pharmacist owner kept in regular contact with the team when they were not working. And team members used an online chat platform to keep each other up to date with information. The SI used their experience to identify areas for improvement in the delivery of pharmacy services and shared their suggestions with the pharmacist owner. This included improving the information provided to people who received their medication in multi-compartment compliance packs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately sized for the volume of services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were small, particularly the dispensary which had limited space for the team to work and store medicines. And there were no options available to expand the premises within the confines of the village shop. Team members generally managed the space well and worked in a tidy and organised manner. Dispensing benches were mostly free from clutter to help reduce the risk of errors. However, a few baskets containing completed prescriptions were stored on the floor in the dispensary. And some of the shelves holding stock were close to the ceiling and to the lights. This added a health and safety risk to team members retrieving stock from these high shelves. And the proximity to the temperature generated from the lights may impact on the quality of the medicines stored in that area. The room temperature in this area was not monitored to identify if it went outside the range recommended by the medicines manufacturer. There was adequate internal lighting for the team to work but natural light was limited due to the main window being partially obscured by the storage shelves.

There was a soundproof consultation room for the team to have private conversations with people and when providing services such as flu vaccinations. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a small range of services that supports local people's health needs. And it generally manages its services well to help people receive appropriate care. Team members obtain medicines from reputable sources and they adequately store and carry out checks to ensure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy through the village store which had a step-free entrance. Team members asked appropriate questions when selling over-the-counter (OTC) products and they knew when to refer to the pharmacist. They provided people with information on how to access other healthcare services when requested.

Around 29 people were provided with multi-compartment compliance packs to help them take their medicines. To manage the workload the team generally ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which the team referred to during the dispensing and checking of the prescriptions. Baskets labelled with the person's name and address held the person's prescription, the dispensed packs waiting to be checked and the empty packs the medication was dispensed from. Team members labelled the packs with directions of when to take the medicines and the labels recorded the descriptions of the medication within the packs. But they rarely supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs but had limited information about the medicines they were taking.

Team members managed the small dispensary space to create separate sections for dispensing and the pharmacist's final check. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found the team had completed both boxes. Completed prescriptions were stored in a dedicated area in an orderly manner to help the team easily locate the prescription when the person came to collect. Team members used CD and fridge stickers on bags containing people's medicines to remind them to include these items when handing over the medication. They provided people with clear advice on how to use their medicines and they were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). They knew the information to be provided if a person met the criteria and commented no-one prescribed valproate met the PPP criteria. The pharmacy kept a record of the delivery of medicines to people and asked for a signature on receipt from the person when CDs were handed over. A sample of delivery records showed sometimes the medication was posted or left in the person's doorway. Team members asked the person if it was safe to do this, but they didn't record the person's response. And they didn't check at a later date that this remained a safe option.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock but there were no records of this activity. The recent change of ownership had involved a team of stocktakers who'd removed any short-dated stock. Team members marked medicines with a short expiry date to prompt them to check the medicine was still in date before supply. When medication was removed from the manufacturer's original packaging the team usually labelled the

container holding the medication with the name, batch number and expiry date. This helped to identify any affected stock when there was a medicine recall. However, a white box was found containing strips of metformin from different manufacturers that was not clearly labelled. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. Team members checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the pharmacist owner who shared the email on the group chat. And contacted the team to confirm receipt of the email when they were not working at the pharmacy. In response to the recent alert to remove pholcodine from sale and supply the team had checked for stock and found none.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure its equipment is used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. And they were positioned in a way to prevent disclosure of confidential information. Team members stored completed prescriptions away from public view and they held private information in the dispensary, which had restricted public access. They used cordless phones to ensure conversations with people could not be overheard.

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.