General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Home Pharmacy, Unit 12, Vision Business Park, Firth Way, Nottingham, Nottinghamshire, NG6 8GF

Pharmacy reference: 9011893

Type of pharmacy: Internet

Date of inspection: 26/10/2023

Pharmacy context

This is a distance-selling pharmacy based on a mixed industrial estate. Most of its activity is dispensing NHS prescriptions. The pharmacy also supplies medicines in multi-compartment compliance packs to people who live in their own homes.

Overall inspection outcome

✔ **Standards 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 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

Overall the pharmacy manages the risks associated with the provision of its services. The pharmacy keeps people's private information safely and it keeps the records it needs to by law. The pharmacy has some procedures to learn from its mistakes. But it does not routinely record or review all its mistakes or review its procedures to make sure they are best practise. Better recording of its mistakes and reviewing of all of its clinical governance processes would allow the pharmacy to use the available opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that required updating. The two experienced dispensing assistants said that they had not read the SOPs but they were able to show how they safely dispensed a prescription. The pharmacy had some processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and the aim was to record them in the near miss log. When checked the last entry in the near miss log had been in March 2023. The pharmacy team said that not all near misses were being recorded and that they would discuss it with the pharmacy manger when he returned from holiday.

The responsible pharmacist (RP) record was mainly accurate but there were occasions when the record had not been completed. There was a notice on display in the pharmacy saying who the RP was, but it was for the previous RP. When this was pointed out the pharmacist changed the notice. The entries checked at random in the controlled drug (CD) register during the inspection agreed with the physical stock held. The pharmacy completed occasional CD balance checks, but these were not as regular as the SOP required. This would make it more difficult to resolve a discrepancy if there was a difference between the balance in the CD register and the physical stock in the CD register. The pharmacy did not have any patient-returned CDs in their cupboard, but the pharmacy team did not know where the patient-returned CD register was. Date-expired CDs were clearly marked and separated from stock CDs to prevent dispensing errors.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. But the pharmacy was using an NHS smart card for a person who was not working at the pharmacy that day. Staff changed the card for a member of staff who was present at the pharmacy. Confidential information was destroyed securely. Professional indemnity insurance was in place. The pharmacy team understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person. They highlighted actions that one of their drivers had taken to support a vulnerable person who had suffered a fall.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work together to manage the day-to-day workload within the pharmacy. They have the appropriate qualifications to deliver services safely and effectively. But the pharmacy misses opportunities to improve its services by not listening to feedback from its team members. Also, some ongoing structured training could enhance the service provided.

Inspector's evidence

During the inspection there was one locum pharmacist and two qualified dispensing assistants. While the pharmacy team managed the day-to-day workload of the pharmacy effectively, and the service seen was safe, the team did not have a full understanding of the clinical governance processes that were in place such as the recording and reviewing of near misses. This was because these processes were usually managed by the regular pharmacist who was the owner of the pharmacy. The regular pharmacist was on leave and this lack of knowledge could make it more difficult to manage a situation if a problem occurred. When asked, members of the team said they had raised some concerns with the pharmacy around some of the deficiencies in clinical governance found during the inspection. But because the pharmacist was more comfortable completing tasks himself this meant that tasks the team could complete were carried out by the pharmacist and other tasks were not being completed such as reviewing SOPs and regular running balance audits. Staff were given informal training by the pharmacist, for example they were aware of the recent MHRA guidance on sodium valproate but did not have any other ongoing training to keep their skills and knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. The pharmacy's website provides relevant information to people using its services.

Inspector's evidence

The pharmacy was situated in a unit in a mixed-industrial estate. There was no public access to the pharmacy. The website contained details about who owned the pharmacy, its location and contact details. The dispensary was a good size for the services provided. There was suitable heating and lighting, and hot and cold running water was available. And there was hand sanitiser available. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are mainly suitably managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It mainly stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the pharmacy does not make a record of the action it has taken in response to a recall or safety alert. This makes it harder for the pharmacy to show how it has protected people's health and wellbeing.

Inspector's evidence

The pharmacy was not open to the public. The pharmacy delivered all its medicines to people. Records of delivery were not always completed to create a record showing the medicine had been delivered; the pharmacy team members said they would make sure the records were completed.

The pharmacy team had an understanding of the signposting process and knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate. The pharmacy team was aware of the recent guidance issued by the MHRA on sodium valproate. The pharmacist did not have face-to-face contact with people using the pharmacy's services. But the team said that he did call patients to give them advice over the phone. This included advice when they had a new medicine or if their dose changed. But the team said that the regular pharmacist did not routinely ask patients who were taking medicines that required ongoing monitoring whether they were receiving this monitoring, and what their results were, to make sure that they were taking their medicines safely.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community to help them take their medicines. The pharmacy spread the workload for preparing these packs across the month, using a tracker to make sure they were prepared and supplied on time. Records seen for people who had their medicines in compliance packs included information on changes in medicines and conversations with doctors, which was good practise. Compliance packs seen included medicine descriptions on the packs for the medicines supplied. Medicine descriptions make it easier for people to identify individual medicines in their packs. The pharmacy provided patient information leaflets (PILs) to people each month.

Medicines were stored on shelves, mainly in their original containers. Some original containers had blisters of medicines with different batch numbers and expiry dates from the information on the container. A few medicines that had been de-blistered by mistake had been put in brown bottles. The bottles did not record all the information required such as batch number, expiry date and the date they were put in the bottle. This increased the risk of supplying an out-of-date medicine or a medicine that had been subject to a drug recall. These bottles were subsequently put in pharmaceutical waste bins and the pharmacy team said that they would make sure the required information was recorded in future. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use.

The pharmacy team was date checking medicines but was not making a record of the check. A check of a small number of medicines did not find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacy team explained the process for receiving and actioning drug alerts but did not know whether a record was made. No records were found during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had access to up-to-date reference sources. At the time of the inspection records showed that medicines requiring cold storage the fridge were kept within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances were less than 12 months old and looked in a good condition

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.