General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sterling Pharmacy, 103 Lapwing Lane, West Didsbury, MANCHESTER, Lancashire, M20 6UR

Pharmacy reference: 1033544

Type of pharmacy: Community

Date of inspection: 30/11/2021

Pharmacy context

This is a traditional community pharmacy situated on a shopping-parade in a suburban area, serving the local population. It mainly prepares NHS prescription medicines, and it supplies some medicines in weekly compliance packs to help make sure people take them safely. It provides other NHS services such as minor ailment consultations. The pharmacy supplies some over-the-counter (OTC) medicines via two websites halfpriceperfumes.co.uk and sterlingpharmacy.com. This was an intelligence-led inspection based on information that the GPhC received regarding inappropriate supplies of OTC medicines via the websites, and the inspection specifically focussed on this aspect of the pharmacy's services. 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 does not have written procedures for selling OTC medicines online or in person. And it does not manage the risks associated with selling codeine containing medicines which can cause addiction and are liable to misuse.
		1.2	Standard not met	The pharmacy does not monitor or review online sales of medicines that are liable to misuse or abuse. So it cannot provide assurance that these sales are properly controlled.
2. Staff	Standards not all met	2.2	Standard not met	Untrained staff are involved in supplying OTC medicines which are sold online.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not have effective systems to make sure that online sales of non-prescription medication are safe and appropriate. And it does not properly control online purchases of codeine containing pain-relief medicines which is a serious patient safety concern.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy lacks the appropriate systems and procedures needed to make sure it supplies OTC medicine safely. The pharmacy team does not review or monitor the online sales of medicines that are commonly abused or misused, such as codeine containing pain-relief medicines. And it does not effectively identify or manage the risks associated when selling these medicines online.

Inspector's evidence

The pharmacy had some infection control measures. A screen had been installed on the pharmacy's front counter, and hand sanitiser was available for members of the public and staff members. Face masks and latex gloves were available for staff members to use.

The superintendent was the responsible pharmacist (RP) at the time of the inspection. He was aware of which OTC medicines were considered high-risk. He confirmed that the pharmacy had never stocked OTC codeine linctus and the OTC pseudoephedrine products had been removed from public view in the pharmacy after reviewing the risks associated with these medicines. However, the pharmacy had not formally assessed the risks involved in selling OTC medicines liable to misuse online, such as codeine containing pain relievers. The pharmacy did not have a system for monitoring and reviewing sales of these medicines, which meant it did not identify any inappropriate request or emerging patterns that raised a concern. So, it could not provide assurances that it was selling these OTC medicines safely. The superintendent stated that the pharmacy did not have any written procedures for selling OTC medicine either online or in person. So, pharmacy team members might not fully understand their responsibilities and supply medication when it is unsafe or inappropriate to do so. The superintendent confirmed that he was the only pharmacist involved in screening the online medicine requests that the pharmacy received. The pharmacy did not have a system for requesting additional information or recording communications with people who requested medicines online. So it could not demonstrate how it made extra checks to make sure that these requests were appropriate and it was safe to supply to supply the medicine.

The pharmacy had written procedures for the safe dispensing of medicines that it kept under review, and this service generally appeared to operate safely. The superintendent had recently completed a course on similar sounding medicine names to help make sure the correct prescription medication was selected when preparing them for supply. He provided an example of how this had been implemented. The pharmacy team recorded and addressed any mistakes it identified when dispensing medicines. However, staff did not always record why mistakes happened. So, they could be missing additional opportunities to identify patterns and mitigate risks in the dispensing process.

The pharmacy had professional indemnity insurance cover for the services it provided. The RP displayed their RP notice in the pharmacy, which helped people to identify them. The pharmacy maintained the records required by law for the RP. It kept electronic invoices of online OTC medicine sales, so it had a record of these supplies. The superintendent confirmed that pharmacy team members had completed training on maintaining people's confidentiality.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to provide safe and effective services. New team members receive appropriate training. But untrained staff sometimes undertake tasks which they are not qualified to do. And the pharmacy does not provide much ongoing training, so the team may have gaps in their skills and knowledge.

Inspector's evidence

The superintendent worked four days a week as the RP and managed the pharmacy's services. A trainee medicine counter assistant (MCA), a dispenser who provided front counter cover, and a delivery driver were present during the inspection. The pharmacy also employed a pharmacy undergraduate student. Service demand had increased during the pandemic, but it had plateaued, and the pharmacy had enough staff to manage its workload.

The delivery driver, who started working at the pharmacy in September 2021, occasionally worked on the front counter. They were about to be enrolled on an MCA training course.

The trainee MCA, who started working at the pharmacy in September 2020, had completed around three quarters of their training course. They had recently decided to delay completion of their training, but their progress had not been reviewed or discussed with the superintendent. And the dispenser had completed their training around twenty years ago, but the pharmacy did not provide any formal ongoing training. So team members may have gaps in their skills or knowledge.

The staff wokred under the supervision of the RP whilst working in the pharmacy. The trainee MCA who worked on the counter confirmed that they were familiar with the questions used to query people's OTC medicine requests to make sure sales were appropriate when they visited the pharmacy. They understood that they needed to exercise extra vigilance with medicines liable to abuse or misuse such as codeine-based pain relief products. They refused the sale and referred individuals to their GP if they had taken the medicine recently. And they only sold one pack of codeine-based products when people requested two or more packs. They could recall a few individuals who had attempted to repeatedly purchase codeine-based products. They advised these patients that these medicines could be addictive, and they should consult their GP if their pain was persistent. And they usually spoke to the pharmacist if they needed support with these requests.

The pharmacy employed another staff member who worked two days each week packing OTC medicines requested online. However, they had not completed an accredited MCA training course, so they did not have the appropriate qualifications for the role in which they were working.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s services. There is a private consultation room, so members of the public can have confidential conversations and maintain their privacy. The pharmacy's websites contain basic information about the pharmacy and how to contact it.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. The dispensary had enough space, so the staff could dispense medicines safely. And the staff could secure the premises to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. Its availability was advertised in the front window, which helped people know about this facility.

The superintendent's details, including their registration number, the pharmacy's parent company's identity, the pharmacy's telephone number and email addresses were displayed on both websites. The pharmacy's address was also displayed on these websites, but its registration number was not included. A link on the websites to the GPhC website helped people to confirm the pharmacy's registration status.

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

Summary findings

The pharmacy’s online services do not operate safely. It does not make sure that sales of OTC medication are suitable for the person requesting the medicine. And it does not properly control the purchase of codeine containing pain relief medicines, which is a serious patient safety concern.

Inspector's evidence

A wide range of OTC medicines were listed on both of the pharmacy's websites. The superintendent explained that on average the pharmacy received around three online OTC medicine requests each day.

The superintendent confirmed that neither of the pharmacy's websites had any automated features for verifying the identity of people opening an online account with the pharmacy. And the pharmacy did not complete any manual checks of people's identity when they purchased medicines. So, there was a risk that an individual could create multiple accounts and order large amounts medicines. And the pharmacy did not check a person's purchase history or have a system for identifying repeat requests for medication.

Both websites permitted people to add large quantities of the same or similar medications to their basket. Neither of the websites had online questionnaires and people did not have to provide any other information when they requested a medication such as why they needed it, their symptoms or whether they were taking any other medication. So the pharmacy did not follow a questioning framework when selling pharmacy medicines online to determine if the supply was appropriate.

The superintendent, who was the only pharmacist who reviewed the pharmacy's online medicine requests, said that he routinely checked the quantity requested. However, over the course of a year the pharmacy had repeatedly sold large quantities of codeine-based pain relief products online to one person using a single online account. The superintendent confirmed that codeine-based products had been removed from the Sterling Pharmacy website during the summer of 2021 and they had subsequently been removed from the perfume website. After the inspection he confirmed that he had closed down both of the websites.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. All pharmacy only medicines were stored behind the front counter and the pharmacy suitably secured its CDs. The team monitored the medication refrigerator storage temperatures. Records indicated that the team regularly date checked the medicine stock. The superintendent confirmed that pharmacy team members had completed training on stock control and rotation, which helped to make sure medication stock had a reasonably long shelf life.

The pharmacy supplied medicines sold online in bubble-wrap packaging. It used an external courier to deliver these medicines, which were delivered within two days of dispatch. The recipient had to sign to confirm they had received the medicine, which the pharmacy could view online. So these medicines were supplied in a timely and secure manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. And it has the facilities to secure people's information.

Inspector's evidence

The superintendent confirmed that pharmacy team members had received training on maintainig the premises' hygiene and cleaning routines. During the pandemic the team sanitised the work surfaces, front counter, IT equipment, telephones, door handles and light switches each working day. A deep clean was completed every two weeks.

The team had facilities that protected peoples' confidentiality. It viewed people's electronic information on screens not visible from public areas and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public view.

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.