General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dock Pharmacy, 128 Dock Road, TILBURY, Essex, RM18 7BJ

Pharmacy reference: 1091481

Type of pharmacy: Community and distance selling

Date of inspection: 26/05/2021

Pharmacy context

The pharmacy is located on a high street and is open for extended hours. The pharmacy also provides services at a distance from its website (www.dockpharmacy.com). The community pharmacy services are provided from the ground floor. And the online services are provided from the upper floor to which members of the public didn't have access. The downstairs community pharmacy mainly dispenses NHS prescriptions. And supplies some medicines in multi-compartment compliance packs to people who need help managing their medicines. The online pharmacy dispenses and supplies private prescriptions that people send in and sell over-the-counter medicines. The inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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 adequately identify or manage the risks associated with selling codeine and dihydrocodeine-based analgesics at a distance. It purchases and sells large amounts of codeine-based analgesics. The pharmacy does not have the appropriate governance in place to manage this situation. And it does not keep records about the action it has taken to ensure medicines which are addictive, or can be misused are sold safely. This means people's health is at risk.
		1.2	Standard not met	The pharmacy is not selling codeine and dihydrocodeine-based analgesics safely online. It does not have any systems or use audit trails to identify, monitor and review sales of this medicine.
		1.5	Standard not met	The pharmacy's professional indemnity insurance does not fully cover all its services. For example, sending medicines to the United States and Canada
		1.8	Standard not met	The pharmacy is failing to safeguard vulnerable people. It does not have sufficient safeguards in place to make sure online over-the-counter supplies of codeine and dihydrocodeine-based analgesics are appropriate.
2. Staff	Standards not all met	2.3	Standard not met	There is evidence that excessive quantities of pharmacy (P) or general sales list (GSL) medicines are being sold without challenge. And the responsible pharmacist does not have the appropriate level of oversight to ensure that the pharmacy sells its medicines online safely.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website does not include all the required information including details of the owner or superintendent pharmacist or how to check the superintendents registration status.
4. Services, including medicines	Standards not all met	4.2	Standard not met	The pharmacy is purchasing and selling excessive amounts of codeine-based analgesics without having appropriate

Principle	Principle finding	Exception standard reference	Notable practice	Why
management				safeguards to prevent its misuse and abuse. The pharmacy supplies medicines to people who are not based in the UK without carrying out checks to see if these medicines can be sent to people in other countries.
		4.3	Standard not met	The pharmacy sends prescription-only medicine stock to UK prescribers and abroad without holding any relevant licenses.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not have the appropriate safeguards in place to identify, monitor and manage all the risks associated with selling codeine-based painkillers online. It is buying and selling large amounts of codeine-based painkillers, and these could be abused and cause harm. This risks people's safety and means that people are not properly safeguarded. The pharmacy does not have appropriate indemnity insurance for all its services. For example, supplying medicines to the United States and Canada. The pharmacy's practices relating to its other services are generally safe. This includes managing the risks associated with COVID-19.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available, and team members had read them. The pharmacy had systems in place to identify and manage the risks associated with some of its other services. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day. Team members had been provided with personal protective equipment (PPE). The responsible pharmacist (RP) who was also the superintendent pharmacist (SI) explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff. Team members were observed to maintain distance whilst working.

There was an SOP for selling over-the-counter (OTC) medicines online. However, this made no reference to the sales of medicines online which could be misused such as those containing codeine or pseudoephedrine. There was no further documented policy or specific information seen on how to manage excessive requests or the risks of selling these medicines.

The pharmacy's online business involved the supply of prescription-only medicines (POMs) against private and veterinary prescriptions sent in by people. And the sale and supply of pharmacy medicines (P) to people across the world including the United States, Canada and Russia. The pharmacy website also signposted people to a prescribing service provided by PharmaDoctor but team members said they had not supplied any medicines via this route. The pharmacy owner was asked if risk assessments were carried out and presented a document which detailed how risk assessments were to be done. However, no evidence was seen of actual risk assessments that had been carried out. The most commonly bought P medicines via the website were Hiprex (an antibacterial), and codeine-based analgesia.

The pharmacy's team members, including the RP, were aware that OTC codeine-containing medicines were addictive. The team member who was responsible for the administration of the online business and printing requests said that she passed on all requests to the pharmacy owner who then showed these to the RP. Information provided to the RP included a completed questionnaire for people buying a medicine for the first time. For repeat purchases the team member explained that the person did not need to complete the questionnaire. The RP was not supplied with details of previous purchases, and so was not able to easily see when people were ordering medicines frequently. The team did not document any details of refusals and there was also no documentation of any medicines which had been returned by the courier due to failed deliveries. This limited the ability of the pharmacy to demonstrate that its team members had been taking appropriate steps to prevent misuse from

happening. There had been no details documented of any interventions made with OTC sales of codeine-based analgesics online. There was no or very limited oversight of the requests and sales of codeine and dihydrocodeine-based analgesics by the RP. The pharmacy did not have a record of the maximum quantities of medicines that could be supplied over a period of time. Team members said that people could only add one pack of certain medicines to their basket and the administrative assistant said she would not send out more than two orders of the same medicine in one month. However, from the records seen this was not always the case. It was seen at the pharmacy that there were multiple occasions where people had purchased more than one codeine or dihydrocodeine-containing analgesic or a combination of both on the same day or within a short period of time. There was one instance where someone in the United States had purchased a combination of codeine and dihydrocodeine-based analgesics 24 times in a period of three months. Information sent by the director following the inspection stated that a new algorithm had been put into place on the website which would prevent repeat orders within 60 days and would prevent any codeine-based product from being reordered by the same customer. On some occasions the director (who was a pharmacy technician) made a record on the person's electronic record of medicines being supplied to individuals. However, this was not seen to be the case in all instances.

Following the inspection, the director of the company said that a risk assessment had been completed, following which additional steps would be taken before codeine-based analgesics and Hiprex were supplied to people. However, the risk assessment was not provided to the inspector so it has not been possible to examine it.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). The RP informed the team member responsible for the mistake and discussed how and why it had happened. In the event that a locum pharmacist had made a mistake the RP called the pharmacist to discuss the mistake as well as taking and sending them a photograph. The RP reviewed near misses from time to time as a result of which she had separated different strengths of medicines on the shelf. The RP said that all medicines were checked before they were handed-out. And she was not aware of any recent dispensing incidents. The RP said that in the event that a dispensing incident were to occur a record would be submitted on the National Reporting and Learning System (NRLS).

The correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy contacted their indemnity insurer during the inspection, to confirm if their policy covered claims from people accessing services abroad. The RP confirmed that supplies to the United States and Canada were not covered by the policy. The pharmacy's insurer also expected members to contact the medicines service and seek advice on sending medicines abroad as well as checking with customs if certain medicines were fine to be sent abroad. The pharmacy had not taken any of these additional steps or carried out any checks. The pharmacy had a complaints procedure. The RP was not aware of any recent feedback or complaints received for the pharmacy services provided downstairs.

Records for unlicensed medicines dispensed, controlled drug (CD) registers and RP records were well maintained. CD running balances were checked regularly. CDs that people had returned were recorded in a register as they were received. Private prescription records did not always have the correct prescriber details recorded. And emergency supply records did not always have the nature of the emergency recorded. This could make it harder for the pharmacy to find out these details if there was a future query.

An information governance policy was available and all team members had been briefed on this. Relevant team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR) and consent to access these was gained verbally.

Pharmacists had completed level two safeguarding training and team members had completed level one training. Contact details for safeguarding boards were available in the main dispensary. However, a large proportion of the medicines the pharmacy sells as part of its online service were ones which were liable to abuse. And it was not clear that the pharmacy had robust safeguarding procedures to help mitigate this risk and sufficiently protect people using this service.

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

Summary findings

The pharmacist has little clinical oversight of the supplies made through the online side of the business. And this means that people using this service may not be protected properly. However, the pharmacy otherwise has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team comprised of the RP, a trained dispenser and a trainee medicines counter assistant started their shift during the inspection. And they were based on the ground floor of the pharmacy. On the upper floor, the online team comprised of the director (pharmacy technician), an administrative assistant and another member of staff who said he did not work at the pharmacy and then said that he was doing work experience and had been there for a few months. The administrative assistant had worked at the pharmacy for over 10 years. The director carried out all the dispensing for the online business. The RP had been the SI at the pharmacy since February 2021. The RP said that she was able to manage the workload in the downstairs dispensary but because this was so busy, she did not have much to do with the running of the online business. And this means that she had limited opportunity to have clinical oversight of the medicines supplied from the online business. Following the inspection the director emailed the inspector and said the pharmacy was looking into employing a second pharmacist for the online side of the business.

The team's performance was informally monitored, and informal meetings and discussions were held when required. Team members were all part of a group chat on an electronic messaging application and this was also used to share information. There were no targets in place for staff.

The trained dispenser asked relevant questions before selling OTC medicines. He had tailored the way in which he asked questions to make it more personal and knew when to refer to the RP if he was unsure or if excessive requests were seen.

Team members who worked in the downstairs dispensary and the director had all either completed appropriate accredited training courses or were enrolled on courses. Team members completed training courses using the CPPE website. The pharmacy was in the process of becoming a healthy-living pharmacy. The trained dispenser was completing the training to become a health-living champion and completed most training at home. Team members were not given set-aside time to complete any additional training. The team had held a meeting before becoming a healthy-living pharmacy to discuss the service.

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

Summary findings

The pharmacy's website does not give people details of the pharmacy’s owner or superintendent pharmacist is. It does not also give people information on how they can check the superintendent’s registration status. However, the pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

On the ground floor, the pharmacy was clean and bright. The dispensary was tidy and organised. Stock was organised in a tidy manner on the shelves in the dispensary. The retail area was well laid out and a sink was available for the preparation of medication. Cleaning was done by the team and a team member was seen to wipe down the counter through the course of the inspection. Clear plastic screens had been fitted at the medicines counter and the number of people allowed into the pharmacy at any given time was controlled. Floor markings had been stuck to the ground.

The first floor contained a studio flat which was vacant and another section with four additional rooms. Three of these rooms were used for the online pharmacy business. One of the rooms within this section was locked and could not be accessed during the course of the visit. The director of the company said that this was used by another business owner who only accessed the room during the pharmacy's opening hours. The very top floor of the premises contained two flats.

A consultation room was available which was accessible from the shop floor and was kept locked when not in use. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature in the dispensary.

The pharmacy's website displayed the GPhC voluntary logo. The website did not display the name of the owner and superintendent pharmacist. The website contained details of how people could contact the customer care team and had a number to call. There was no clear information on how people could give feedback and raise concerns.

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

Summary findings

The pharmacy does not provide all of its services safely. It has limited systems to ensure online supplies and sales of higher-risk medicines are made safely. It is unable to satisfactorily justify the large quantities of codeine-based analgesics and other medicines liable to abuse that it orders and supplies. And it is not doing enough to satisfy itself that people are not at risk of becoming addicted. The pharmacy obtains its medicines from reputable sources. But it does not manage all of its medicines appropriately. The pharmacy provides most of its other services in an appropriate way.

Inspector's evidence

The range of services offered by the pharmacy was adequately promoted. Access into the premises was via a single step from the street, team members would go and help people who required assistance. There was easy access to the counter. Team members were multilingual and spoke a range of languages which covered those spoken locally. Team members were aware that signposting may be necessary where people required an additional or alternative service. Prior to the Covid-19 pandemic, all instances of signposting had been recorded, and the RP said she planned to restart this as the workload returned to normal. The pharmacy had the ability to produce large-print labels when needed.

Prescriptions in the downstairs dispensary were received electronically, then printed out and labels were processed and placed in a basket. The medicines were dispensed by the RP and also checked by her. The RP said that a third check was done by the team member who handed out the prescription. Taking a mental break in between dispensing and checking the prescription was discussed with the RP. Dispensed and checked-by boxes were available and used. Baskets were used to separate prescriptions, preventing transfer of items between people.

As part of the online business the pharmacy dispensed and supplied medicines against private prescriptions. People were required to send in the original prescription before the order was dispatched. Some vets also sent prescriptions directly to the pharmacy. The director said veterinary prescriptions were more commonly dispensed then human medicines.

The RP was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. She said these were always dispensed in their original packaging. When dispensing medicines which required monitoring a 'pharmacist' sticker was attached to the prescription. For people collecting warfarin the RP asked to check their yellow book and checked if they were having regular blood tests.

Multi-compartment compliance packs were prepared at the weekend when it was quieter. Prescriptions were ordered in advance. Changes were queried with the prescriber and a record was made on the person's individual record. Assembled multi-compartment compliance packs seen were labelled with product details and mandatory warnings. Information leaflets were supplied monthly.

The pharmacy provided a delivery service and during the pandemic the number of people who the pharmacy delivered medicines to had increased. Signatures were no longer obtained when medicines were delivered, and this was to help infection control. In the event that someone was not available medicines were returned to the pharmacy. Medicines sent for online orders were sent to people via

Royal Mail or other courier services. The pharmacy did not supply any fridge lines as part of the online service.

The pharmacy's online services were accessed via the Dock pharmacy website. The website gave the address of where medicines were supplied from but did not give details of the SI and RP. People were required to create an account to checkout their basket. No identification (ID) checks were carried out as part of the registering process. The director of the pharmacy said credit checks were done at the point when payment was taken. There were no additional age verification checks. Following the inspection, the director informed the inspector that ID and age verification checks had been introduced and that these were carried out through a third party. When ordering medicines for the first time, people were required to complete a questionnaire. This was not required for repeat requests.

In general, the team did not usually make contact with people following a supply to ensure that they knew how to take their medicines properly. People could communicate with the pharmacy via telephone or email. The administrative assistant was the first point of contact, but it was unclear if any queries were passed on to the RP.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. There were no date-expired medicines found on the shelves checked. Fridge temperatures were checked daily and recorded. These were observed to be within the required range for the storage of medicines. Out-of-date and other waste medicines were disposed of in the appropriate containers which were kept separate from stock and collected by a licensed waste carrier. A Schedule 3 CD was found in the clinical waste bin. This was brought to the attention of the RP who gave an assurance that she would ensure this did not reoccur. Prescriptions for all CDs were highlighted, and people were called a few days before their prescription was due to expire to remind them to collect. Drug recalls were received via email and these could be accessed by all team members. Previously alerts had been printed and filed. The RP gave an assurance the she would ensure there was an audit of actioned alerts.

Pharmacy stock was manually ordered by the RP for the main dispensary and the director for the online activity. Invoices for both the downstairs and upstairs were filed together and all stock was stored in the dispensary downstairs. Invoices for the month of May were reviewed during the inspection. It was found that the pharmacy was ordering large quantities of medicines including salbutamol inhalers. Records of these dispensed and stock held in the pharmacy showed an inconsistency. The RP and director confirmed the pharmacy were supplying medicines to another pharmacy in Nigeria. The pharmacy also supplied medicines to two private doctor's practices against written requests issued for stock. The pharmacy did not hold a wholesale dealers licence (WDL) with the MHRA or hold an export licence.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. Separate measures were used for certain liquid CDs to avoid contamination. A medical fridge of adequate size was also available. Up-to-date reference sources were available including access to the internet. A blood pressure monitor was available, but this was not being used during the pandemic. The RP said this had been replaced following the previous inspection and did not require calibration. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was segregated and shredded.

The pharmacy team said that the systems used for the services provided online were secure. Computers in the upstairs offices were password protected. The offices were locked at the end of the day and were not accessible to tenants or other pharmacy staff.

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.