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

Date of inspection: 16/02/2022

Pharmacy context

The pharmacy is located on a high street and is open for extended hours. It mainly dispenses NHS prescriptions. And supplies some medicines in multi-compartment compliance packs to people who need help managing their medicines. The pharmacy also provides services at a distance and from its website (www.dockpharmacy.com). People can buy over-the-counter medicines from the website. And the pharmacy dispenses private prescriptions from UK-based prescribers. And from a prescriber based in Romania, and sends the medicines out to people via courier. Conditions are in place on this pharmacy premises that prevent some services being provided. These conditions were imposed after failings were identified and they remain in force.

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 identify and manage all of the risks involved with its services, particularly the services it provides at a distance. It has not carried out any risk assessments for the prescribing service it dispenses medicines for. And the pharmacy does not have written procedures for dispensing prescriptions issued by the prescribing service.
		1.2	Standard not met	The pharmacy does not effectively audit the safety of the services it provides to people, particularly the prescribing service it dispenses medicines for. The prescriber for this service is not based in the UK and is not regulated by a UK healthcare regulator. And the pharmacy cannot demonstrate that the prescriber is following UK prescribing guidance. The pharmacy doesn't make checks about how the prescribing service shares and receives information from people's regular prescribers to make sure this information is used effectively to protect people's health and wellbeing.
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 not all met	4.2	Standard not met	The pharmacy does not always make sure that the prescribing service it dispenses medicines for has obtained enough information from people to support the safe supply of prescription medicines. It does not ensure that the prescribing service has adequate systems in place to make sure relevant information about people's treatment is shared with other health professionals involved in the care of the person. Or, make sure that appropriate monitoring and follow up arrangements are in place, when supplying prescription medicines such as asthma inhalers.
5. Equipment	Standards	N/A	N/A	N/A

Principle	Principle finding	Exception standard reference	Notable practice	Why
and facilities	met			

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

Summary findings

The pharmacy's working practices are not always safe. The pharmacy does not appropriately identify and manage all the risks associated with the services it provides. It has carried out some risk assessments and audits but does not properly review all its services to make sure that they are safe for people to use. For example, it has not carried out risk assessments for the transcribing service it dispenses medicines for. And it doesn't make checks about how the prescribing service shares and receives information from people's regular prescribers to make sure this information is used effectively to protect people's health and wellbeing. The pharmacy's practices relating to its other services are generally safe.

Inspector's evidence

The pharmacy dispensed prescriptions that people brought in. And its online business included the supply of prescription-only medicines (POMs) against private and veterinary prescriptions sent in by people and private prescriptions issued by a prescriber based in Romania. The Romanian prescriber transcribed and issued prescriptions which were then sent to the pharmacy for dispensing, and the medicines were sent to people internationally. The pharmacy also sold and supplied pharmacy (P) medicines to people across the world including the United States, Canada and Russia. The most commonly bought P medicines via the website were emollient creams and Hiprex (an antibacterial). Since the previous inspection, audits had been carried out on the sales of P medicines online. However, there was no risk assessment available for the third-party prescribing service for which the pharmacy dispensed prescriptions for. The prescriber was not registered with a relevant UK regulator, and the additional risks associated with this had not been appropriately considered. The pharmacy was unable to provide any documentary evidence of any audits carried out for this service. However, the director of the company said that they had reduced the number of salbutamol inhalers dispensed from six to three. The pharmacy had not carried out any checks on how the prescriber communicated with people. And other than the fact that the pharmacy was aware that the prescriber had details available of the primary prescriber, they were unable to provide evidence of any checks carried out to assure themselves that the primary prescriber was aware of the medicines being prescribed. Or of the arrangements in place for the ongoing monitoring of people using this service. The pharmacy was also unable to provide evidence of information they had gathered in relation to the prescribing policies which were being followed by the prescriber.

The pharmacy had standard operating procedures (SOPs) available, and team members had read them. However, SOPs did not cover all aspects of the pharmacy's distance-selling services including the transcribing service which it dispensed medicines for. 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.

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 responsible pharmacist (RP) informed the team member responsible for the mistake and discussed how and why it had happened. A record of the mistake was also made. The RP said that all medicines were checked before they were handed out. The RP gave an example of a near miss where a team member had identified that the wrong quantity of medication had been dispensed as part of this third check

prior to handing the dispensed medicines out. The RP was not aware of any recent dispensing error and said that in the event that a dispensing error were to occur a record would be submitted on the National Reporting and Learning System (NRLS). There had not been any recent dispensing errors since the pharmacy had introduced the third check. The pharmacy team reviewed dispensing mistakes and as a result of past reviews warning labels had been added to some shelf edges. Any trends, patterns and action points were shared on the group chat on an electronic messaging application.

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. A separate policy was in place to cover supplies of medicines sent to the United States and America. The overseas prescriber had insurance in Romania, the pharmacy had used a translation site to seek assurance that this was adequate for the service provided.

The pharmacy had a complaints procedure and also carried out annual patient satisfaction surveys. The company director described how more staff had been employed after feedback was received about waiting times.

Records for private prescriptions, emergency supplies, 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. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored under the counter and people's private information was not visible to others using the pharmacy. An information governance policy was available and team members had been briefed on this. Confidential paperwork and dispensing labels were segregated and shredded. 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 sold 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 met

Summary findings

The pharmacy 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 company director, who was a registered pharmacy technician, a trained dispenser, a trainee dispenser, an administrative assistant, a trained medicines counter assistant (MCA) and three trainee MCAs. There were two permanent pharmacists who covered regular shifts, the superintendent pharmacist (SI) worked two to three shifts per week. The pharmacy had a bank of nine locum pharmacists who regularly worked at the pharmacy. Team members were all trained or undergoing training. Team members were able to manage their workload during the inspection. The RP felt that there were now an adequate number of staff.

Individual performance and development was monitored by the SI who held appraisals with each of the team members. There was no fixed interval for meetings and they were held as and when the SI felt it was needed. Team members were also provided with ongoing feedback from the pharmacists.

The trainee MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She described checking with the RP before selling any medicines. She was aware of the maximum quantities of certain medicines which could be sold over the counter.

Team members were given pharmacy magazines to read to update their knowledge and were asked to read up on particular seasonal topics to refresh their knowledge. Pharmacists briefed them on new products and tested their understanding from time to time. Team members completing formal training courses were provided some study time when it was quiet or worked through their training material at home. They were well supported by the pharmacists and described using the group chat to ask more experienced colleagues for help if they did not understand particular sections.

Team members discussed issues as they arose and information was shared on the group chat. Any updates were printed and left for team members to read when they started their shifts. The latest update had been in relation to monkey pox. Team members felt able to provide the company director with feedback and suggestions. There were no targets for the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's website gives people details about the pharmacy which dispenses their prescriptions. 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. Clear plastic screens had been fitted at the medicines counter.

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. The director of the company had previously said that the other room 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 and had details of the pharmacy owner and superintendent pharmacist. The website contained details of how people could contact the customer care team and had a number to call. The associated prescribing service was not accessible from the pharmacy's website.

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

Summary findings

Some of the pharmacy's services are not always managed effectively, to protect people's health and wellbeing. The pharmacy does not make adequate checks about the prescribing service for which it dispenses prescriptions. For example, it has no information on the checks carried out by the service or of the consultation process. And it does not have any information about the ongoing monitoring of people with long-term conditions who use this service. This increases the risk that the pharmacy supplies prescription medicines to people which are not clinically appropriate and people's conditions might not be properly monitored. However, the pharmacy obtains its medicines from reputable sources and it stores them properly.

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. The pharmacy had the ability to produce large-print labels when needed.

As part of the online business the pharmacy dispensed and supplied medicines against people's existing 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 pharmacy's online services for existing prescription dispensing and medicines sales were accessed via the Dock pharmacy website. People were required to create an account to checkout their basket. Identification (ID) and age verification checks were carried out using a third-party company. When ordering medicines for the first time, people were required to complete a questionnaire. Team members explained that this was not required for repeat requests. Following the inspection, the director clarified that the website did not have a reorder function. All products had to be chosen and product related questions had to be answered each time.

In general, the team did not usually make contact with people following an online supply to ensure that they knew how to take their medicines properly. However, following the inspection the director of the company explained that for some medicines people were provided additional information by email and people were also requested to read the patient information leaflet and contact the pharmacy if they had additional questions or speak to their GP if symptoms did not improve. However, evidence for this was not provided during the inspection, in the response provided after by the director of the company generic information on taking over the counter and prescription medicines which was emailed to people was sent. People could communicate with the pharmacy themselves 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. On the day of the second visit the administrative assistant had not been working. Following the inspection the director of the company said emails were replied to within 24 hours when the assistant was off work and telephone messages were responded to within 24- 48 hours. Orders were processed and given to the RP with any relevant papers. The RP on the first visit explained that she had independently called some people to seek further information before authorising requests for some

online orders for over-the-counter medicines.

For online Hiprex sales the pharmacy required up-to-date proof that the person had been requested to take the product by a medical practitioner. The website had a note for people requesting them to submit a document from their doctor or consultant to show that they had been advised to take this. Failure to submit this information resulted in the order being cancelled. A copy of this document along with a form completed by the administrative assistant and the completed questionnaire was handed to the RP. The administrative assistant also completed checklist forms for other over-the-counter sales and for private prescriptions received. Private prescriptions were not processed and dispensed until the original prescription form was received by the pharmacy. The administrative assistant explained that repeat orders for over-the-counter medicines were infrequent. There was no policy for the maximum quantity of medicines which could be supplied. The administrative assistant described how she would make a judgement call for these. The RP described how the owner annotated request forms with the number of times the person had been supplied the medication in the past. A maximum of one item was sent for medicines such as Phenergan and if it was reordered within a month the order was not processed. Following the inspection the director of the company introduced a new policy which allowed for only one pack of certain restricted products to be ordered at a time with a 30 day order interval in between orders.

The pharmacy also dispensed prescriptions for a prescriber based in Romania who transcribed prescriptions for international patients. This prescriber issued a new prescription which was then sent electronically to the pharmacy. Medicines were then dispensed by the pharmacy and sent via a courier service direct to the patient. For the overseas prescriber, the pharmacy had only carried out checks on the whether the prescriptions could be legally dispensed. The pharmacy had no contact with people who it supplied medicines to via this service, and the pharmacy could not provide any evidence of any counselling provided. The pharmacy was unsure of which clinical guidance the prescriber was following and was unable to provide evidence that checks had been carried out for the interaction between the prescriber and the patients. There was no evidence available or provided as to what the consultation process involved, or how the prescriber contacted people. Or any records that the prescriber had made or details of ID checks they had completed. The Romanian prescriber sent electronic prescriptions for this service directly to the pharmacy, and hard copies were not sent. The pharmacy dispensed these and sent them to people via courier to people living in countries around the world.

The director of the company said that following an audit the pharmacy had decided to only dispense three salbutamol inhalers when the prescriber had written six. There was no written evidence provided for this audit. The pharmacy was not carrying out any checks as to whether the person was also using a steroid inhaler. And the pharmacy did not check how the person had been assessed or about any ongoing monitoring the person was receiving.

NHS prescriptions in the downstairs dispensary were received electronically, then printed out and the labels were generated and placed in a basket. The medicines were dispensed by the dispenser and checked by the RP. On some occasions the RP had to self-check although she said this was rare. The RP said that a third check was done by the team member who handed out the prescription. Dispensed and checked-by boxes were available and used, to help provide an audit trail. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. A poster was also displayed in the dispensary to prompt team members. 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 and the 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, and the patient information leaflets were supplied monthly.

The pharmacy provided a delivery service. 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 items requiring cold storage as part of the online service.

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. Drug recalls were received via email and these could be accessed by all team members.

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 cross-contamination. A medical fridge of adequate size was also available. Up-to-date reference sources were available including access to the internet. 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.