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: 22/06/2023

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. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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's working practices are generally safe and effective. People who use the pharmacy can give feedback about its services. The pharmacy keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process.

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. The pharmacy also sold and supplied pharmacy (P) medicines to people. The most commonly bought P medicines via the website were emollient creams and Hiprex (an antibacterial).

The pharmacy had standard operating procedures (SOPs) available, and these included specific SOPs for providing services at a distance. Team members had read the SOPs relevant to their roles. However, SOPs did not cover all aspects of the pharmacy's services including the low-volume prescribing carried out by some of the pharmacists. The pharmacy had systems in place to identify and manage the risks associated with some of its other services. There were two sets of SOPs and the director of the company agreed that she would archive one set, so it was clear to the team which ones were current.

Some of the locum pharmacists who worked at the pharmacy including the superintendent pharmacist (SI) were pharmacist independent prescribers (PIPs). A few prescriptions were seen to have been issued by two of the PIPs which included prescriptions for malaria prophylaxis, hypertension and non-steroidal anti-inflammatories. There were no consultation notes seen during the inspection. Following the inspection the director forwarded information relating to the consultations carried out and confirmed that the PIPs had referred to Summary Care Records. And had seen proof of people having prescribed the medicines before and prescriptions had been issued as the person had not been able to see their regular GP. There was no SOP or framework for prescribing and it was unclear if prescribing was covered by the pharmacy's indemnity insurance. One of the locum pharmacists present at the inspection said the prescribing would be covered under the PIP's own insurance.

Following the inspection, the company director provided an assurance that the pharmacy was now not providing a prescribing service. And she would ask pharmacists to suspend prescribing until an SOP had been produced and she had spoken to the pharmacy's insurance providers.

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). Near misses were seen to be recorded consistently. As a result of past reviews, the pharmacy had implemented a second check which was carried out by the pharmacist when a person presented to collect their prescription. Counter staff handed all assembled prescriptions to the pharmacist to double check. Any near misses were amended and recorded. A photograph was also taken and shared with team members. If a mistake was identified as part of the second check before hand-out, the pharmacist who had initially checked the prescription was also notified. Near misses were reviewed by the SI. Following reviews of near misses, medicines had been separated on the shelves, and labels to highlight medicines

which looked or sounded alike had been attached to the shelves to prompt team members to double check. Since the introduction of the second check the number of dispensing errors had reduced and there had not been any recent reported errors. The pharmacy had a process for dealing with these and information would be shared on the group chat on an electronic messaging application.

The correct responsible pharmacist (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. Pharmacists also had independent indemnity cover.

The pharmacy had a complaints procedure and also received feedback online via the website and Google. Feedback was discussed with the team and reviewed. The company director described how, commonly, feedback related to people not receiving their medicines against prescriptions ordered online. In most cases this was due to the pharmacy not receiving the original. The team members would then explain that they required the original prescription before they could send out any medication.

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 about this. Confidential paperwork and dispensing labels were separated and shredded. 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 from people.

The RP had completed level three safeguarding training and team members had completed level two training. Contact details for safeguarding boards were available in the main dispensary. A safeguarding pathway poster was displayed in the pharmacy.

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 provided with ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team comprised of a locum pharmacist, the company director, who was a registered pharmacy technician, a trained medicines counter assistant (MCA) and an administrative assistant. Other team members who were not present included two dispensers, a trained MCA and three trainee MCAs. There were eight regular locum pharmacists plus the superintendent pharmacist (SI) who covered shifts. Team members were all trained or undergoing training. Team members were able to manage their workload during the inspection. The RP felt that there was now an adequate number of staff. The pharmacy was due to reduce their opening hours and had submitted an application to the NHS for this. There was a changeover of pharmacists during the inspection.

The company director had arranged the rota in a way to ensure where possible there were three team members including the RP present at any time. During busy periods an additional team member was added to the rota. As a minimum, there was always at least one other team member with the pharmacist.

Individual performance and development were monitored by the SI and director 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 one was needed. Team members were provided with ongoing feedback from the pharmacists. The 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 completed ongoing training and were provided with set-aside time at work to complete the training. Recent training completed had covered: weight management, inhaler disposal, domestic abuse, antimicrobial stewardship and cancer awareness. Team members were given pharmacy magazines to read to update their knowledge and were asked to read up on seasonal topics to refresh their knowledge. 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 supported by the pharmacists with their training.

Team members discussed issues as they arose, and information was shared on the group chat. Due to the different shifts, information was also shared over calls. Team members felt able to provide the company director with feedback and suggestions and described that there was an open culture. The company director described that the locum pharmacists brought different ideas from their experiences elsewhere. Targets were set for the services provided. Pharmacists were encouraged to provide services. The RP described that these did not affect his professional judgement and due to the extended opening hours, there was more time in the day to provide services.

Principle 3 - Premises ✔ Standards met

Summary findings

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. The pharmacy's website provides people with information about the pharmacy.

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.

The first floor contained a section with four 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.

A consultation room was available which was accessible from the shop floor. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services safely. It obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

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 and 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 was sometimes necessary where people required an additional or alternative service. The pharmacy could produce large-print labels when needed.

The director felt that the blood pressure checking service and emergency hormonal contraception (EHC) had the most benefit to the local population. As part of the blood pressure checking service the pharmacy would make a referral to the person's regular GP if the blood pressure reading was high. The pharmacy's longer opening hours meant it was more convenient for people to access services such as EHC when needed.

As part of the online business the pharmacy dispensed and supplied medicines against people's 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 supplying against private prescriptions and for 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. People could communicate with the pharmacy themselves via telephone or email. The administrative assistant was the first point of contact. All online orders including those for over-the-counter medicines were recorded on the electronic recording system so that details of previous orders could be seen by the RP checking the order. Orders were processed and given to the RP with any relevant papers, the assistant also documented when the last supply had been for medicines if the person had ordered before.

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. 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 Phenergan to be ordered every 60 days.

There was an established workflow for dispensing NHS prescriptions received downstairs. Prescriptions were received electronically, then printed out and labels were processed. People were notified if an urgent prescription was received and ready to collect. A dedicated shelf was used to store incomplete prescriptions. Prescriptions were dispensed by a dispenser and checked by the RP, pharmacists usually worked with dispensers and therefore very rarely needed to self-check. Prescriptions were usually handed out by the pharmacists. Dispensed and checked-by boxes were available and were routinely used. Baskets were used to separate prescriptions, preventing transfer of items between people. For walk-in prescriptions counter staff had been trained to check the expiry date and if any amendments made by the prescriber had been countersigned. These were then handed into the dispensary.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The team did not split packs for sodium valproate and had attached a label to the shelf edge to remind the team. Information had also been shared on the group chat used by team members. The director demonstrated where labels would be attached. Most people who collected sodium valproate from the pharmacy did not fall in the at-risk group. The RP checked people's records to see if they had been supplied with sodium valproate before and also checked with the person if they were aware of the information. If someone was not part of the PPP, the RP counselled them and spoke to the prescriber. Additional checks were carried out when people collected medicines which required ongoing monitoring. The RP ensured people were supplied with leaflets for these medicines. When people collected warfarin, if they had their yellow book this was checked. For other medicines the RP checked if the person was having regular blood tests or showing any side-effects. The pharmacy had leaflets displayed near the area from where people's medicines were handed out. The director said these acted as visual prompts and were also given to people when their medicines were being discussed.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people for this service. New prescriptions were checked against repeat slips once they were received for any changes. Changes were queried with the prescriber and a record was made. In the event someone was admitted into hospital, the team informed the person's doctor and checked on PharmaOutcomes for any updates on discharge medicines. The person's surgery was informed of the changes and new prescriptions were checked to ensure any changes had been made. Team members only prepared packs once all stock was received. Pharmacists checked the medicines before the packs were assembled. Prepared packs were usually checked three times before they were handed out. The pharmacy had individual records for each person. All information was recorded on these. There were no assembled multi-compartment compliance packs available to look at during the inspection. The director showed an example backing sheet. This included product details, but mandatory warnings were missing. Following the inspection, the director confirmed that the settings on the computer system had been changed to include these. Patient information leaflets were supplied monthly.

The pharmacy provided a delivery service. Deliveries were carried out by the director, who always called people before attempting to deliver. In the rare 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 by courier if for next day delivery. The pharmacy used special packaging to post medicines requiring cold storage. No medicines were sent abroad. In the event that there was a failed delivery any returned medicines would be discarded, and a replacement sent to the person. However, the director said this had never happened.

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 storing 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. These were printed out, actioned and filed away. The director said they had actioned recalls for irbesartan and levothyroxine.

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 for measuring liquids accurately, and suitable tablet counting equipment. Equipment was clean and ready for use. Separate measures were used for liquid CDs to avoid cross-contamination. A blood pressure meter was used as part of the services provided. This was fairly new, and the director planned to replace this when needed. A medical fridge of adequate size was 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 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.