General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Quantum Pharmacy, Fairgate House Suite G14, 205 Kings Road, Tyseley, BIRMINGHAM, B11 2AA

Pharmacy reference: 1111188

Type of pharmacy: Internet / distance selling

Date of inspection: 04/07/2024

Pharmacy context

This pharmacy has an NHS distance selling contract and it specialises in providing pharmacy services to care homes. The pharmacy is located in a unit on an industrial estate and people cannot visit this pharmacy in person. Services and information can be accessed through the pharmacy's website, www.quantummeds.co.uk.

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 suitably identify and manage the risks associated its services. It does not have responsible pharmacist standard operating procedures (SOPs) which are required by law. Pharmacy staff do not know which activities cannot be carried out in the absence of the Responsible Pharmacist. And other key SOPs related to the pharmacy's business are missing. The pharmacy does not carry out appropriate written risk assessments before the pharmacy makes a major change to its operational processes, such as its delivery service.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always support its team members to complete essential training for the roles in which they are working. Several of the pharmacy's team members do not have the appropriate qualifications for the role that they are undertaking, nor are they are working towards a qualification.
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 not all met**

Summary findings

The governance arrangements that underpin the pharmacy's service are not sufficiently robust. The pharmacy has written procedures which explain how it operates. But procedures are incomplete, and some team members are unclear about what is expected of them. This means they may not always work effectively or in accordance with legislation. And the pharmacy does not carry out appropriate risk assessments when making major change to its operational processes. Members of the team do not always record things that go wrong. So, they may miss opportunities to learn from them and improve the service they provide. They understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered some of the operational activities of the pharmacy and the services provided. The SOPs had been produced by the superintendent pharmacist (SI) in March 2023. They had been developed using commercially available SOP templates which had been tailored so they were relevant to the way that the pharmacy operated. Roles and responsibilities were highlighted within the SOPs. But the pharmacy did not have the Responsible Pharmacist (RP) SOPs which are required by law, and the pharmacy team were unclear as to what activities could be carried out in the absence of the RP. A trained dispensing assistant was observed dispensing a compliance pack tray before the RP had assumed responsibility for the pharmacy. This is an activity that requires an RP to be signed in. And other useful and relevant SOPs were absent from the SOP file. For example, procedures for managing deliveries and dispensing incidents. This meant that the pharmacy team may not be working in an effective way.

A near miss log was available and near misses were sometimes recorded. The number of near misses recorded was quite low. There were periods where nothing had been recorded which suggested that not all of the near misses were logged. The SI said that near misses were discussed with the dispenser involved to ensure they learnt from the mistake. The SI explained that he reviewed the near miss log for patterns and trends at the end of the month, but he did not record his findings so he could not demonstrate this. And it meant that weren't any records to refer to in the future to assess for effectiveness. The pharmacy did not have an SOP for dealing with dispensing incidents. The SI explained that he thought the dispensers would inform him, or the pharmacy manager, if they were made aware of an incident and it would be reported directly onto the NHS Learning from Patient Safety Events website. There was evidence that suggested that not all dispensing incidents were recorded, so they might not always effectively reviewed and some learning points could be missed.

The main service of the pharmacy was supplying monthly and interim prescriptions to care homes. Some of the care homes were local to the pharmacy and some were in other areas of the country. Deliveries to the local care homes were made by the pharmacy's drivers and the others were made by a courier company. The pharmacy was changing the courier company it used but it had not produced a risk assessment associated with this. This meant it could not demonstrate what checks had been completed and how key risks had been mitigated before changing to the new courier.

The pharmacy manager visited care homes when the care home team requested an audit. The medicines audit was designed to support the care homes with meeting their own regulatory requirements. The pharmacy manager left the care home a copy of the audit, and a list of recommendations.

People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and would involve the pharmacy manager or SI if they could not reach a solution. The pharmacy communicated with the care homes that it supplied medicines to by email as it provided an audit trail for prescription queries, and it was a convenient way for both the care home and the pharmacy to keep in touch.

The pharmacy had up-to-date professional indemnity insurance. The RP notice was displayed in the dispensary and the RP log met requirements. Delivery records were maintained. Confidential waste was stored separately from general waste and destroyed securely by a specialist company. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The SI and pharmacy manager had completed safeguarding training. The pharmacy team understood what safeguarding meant. The pharmacy manager visited care homes and gave examples of types of concerns that he may come across during those visits and described what action he would take.

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

Summary findings

The pharmacy does not always support its team members to complete essential training for the roles in which they are working. This means team members might not always have the knowledge and skills to provide the services safely. The pharmacy has enough team members to manage the workload and the services that it provides. Team members plan absences in advance, so the pharmacy has enough cover to provide the services. They work well together, and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the superintendent (RP at the time of inspection), a pharmacy manager (accuracy checking pharmacy technician), three trained dispensing assistants, three untrained dispensing assistants, and two home delivery drivers. One trained dispensing assistant had recently started a level three qualification. The three untrained dispensing assistants had not been enrolled on accredited training courses within 12 weeks of starting in their roles in keeping with the minimum training standard requirements. And it was unclear whether the employed delivery driver had completed any accredited training.

Holidays were discussed with other team members to ensure no-one else had already booked the same week and cover was provided by other staff members as required. The pharmacy employed some part time dispensing assistants who worked extra hours when required. The pharmacy manager did not plan any care home visits during the full-time dispensing assistant's annual leave, and he worked at the pharmacy to provide cover.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with other tasks when required. Tasks were delegated to different members of the team so that the workload was well managed. The pharmacy staff said that they could raise any concerns or suggestions with the pharmacy manager or SI and felt that they were responsive to feedback. Team members said that they would speak to other members of the team or contact GPhC if they ever felt unable to raise an issue internally. No targets were set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy's website provides information about the pharmacy's services.

Inspector's evidence

The pharmacy used a website; www.quantummeds.co.uk to promote the services offered and to allow people to order repeat prescriptions. The website contained details of the pharmacy such as the name and registration number of the SI, the premises address, the services offered, some health advice information and useful links. The website did not contain details explaining how people could make a complaint or check the registration of the pharmacy or the SI if they needed to. The pharmacy had started using a new website address after the subscription on the previous domain expired. The GPhC voluntary logo was being used on the new website despite it not being the website associated with the logo. The SI agreed to address these issues and correct the website address for the pharmacy on the NHS website.

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the building maintenance department. The premises were clean and tidy with no slip or trip hazards evident. Cleaning was undertaken by pharmacy staff. The sinks in the dispensary had hot and cold running water, hand towels and hand soap available. Toilets and break areas were available in the building's communal areas. The building had communal meeting rooms that the pharmacy could book if they wanted a quiet space. The temperature felt comfortable, and the lighting was adequate for the pharmacy services offered. Prepared medicines were held securely within the pharmacy premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services adequately and it supplies medicines safely. It gets its medicines from licensed suppliers and stores them securely and at the right temperature, so they are safe to use. The pharmacy team effectively supports care home providers to manage their medicines appropriately.

Inspector's evidence

The pharmacy had an NHS distance selling contract, so members of the public did not access the pharmacy premises to collect prescriptions. The pharmacy services could be accessed via their website, telephone and e-mail. Whilst the pharmacy services were available to people across the UK, there was very little demand and majority of the workload was providing monthly and acute prescriptions to local care homes. The pharmacy offered some pharmacy and general sales list medicines for sale through the website, but it had not made any sales, nor was it expecting to. The pharmacy was planning how they would offer the NHS Pharmacy First service as a distance selling pharmacy but were yet to start this service.

Different care homes had their monthly medications provided in either original packs or dispensed into compliance-aid trays. The pharmacy manager tried to encourage care homes to switch from compliance aid packs to original pack dispensing to help improve patient safety. But some of the care homes continued to receive compliance-aid trays as requested by the care homes' management.

The pharmacy supplied regular prescription medication (monthlies) and any additional medication that was be prescribed during the month (acutes). Monthlies were sent to the care homes on a specific date so that the staff at the home could book the medication in and acutes were sent as soon as possible after the prescription was received by the pharmacy. The monthly workload was carefully planned, and the team's progress was monitored by the team leader and a full-time dispensing assistant. Members of the team were assigned different tasks based on the progress of the workload, and these were co-ordinated by the team leader.

Monthly prescriptions were received electronically by the pharmacy and labelled by a dispenser. The dispenser identified if there were any missing items or changes from the previous monthly supply and made a list of these. This list was emailed to the care home and the care home was expected to use this list to action the points and update the pharmacy team. Stock for monthly prescriptions was gathered by a trained dispensing assistant and put into individual baskets for each patient, together with the labelling sheets and prescriptions, and assembled by one of the other team members. The team were aware of the risks associated with the use of valproate containing medicines, and the need for additional counselling. Valproate containing medicines were always supplied in the original packaging rather than in a compliance-aid pack, and the pharmacist liaised with the care home to ensure a Pregnancy Prevention Programme was in place for the resident if relevant.

Acute prescriptions were labelled and dispensed as soon as the prescription was received and placed into a separate area to ensure it was dispensed and dispatched on the same day. If the pharmacy did

not have sufficient stock for an acute prescription, or the courier company had already collected the prescriptions for the next day, the team would telephone the care home to explain the options and agree what to do next. The pharmacy team contacted the care homes if they had any questions about a person's medication or if they had any specific counselling to provide. Email was the preferred method of communication as this provided an audit trail of the interaction.

The pharmacy employed two delivery drivers for local deliveries, and a courier company for national deliveries. The courier company collected at specific times of the day and offered a next day delivery before 10.30am for urgent prescription, such as acute antibiotics. The courier company had been selected as it had facilities for cold chain delivery and the pharmacy manager had checked that it was licensed to transport controlled drugs. Courier deliveries could be tracked using the tracking number and proof of delivery was obtained. Proof of delivery was also obtained for local deliveries. Each delivery contained an itemised delivery note so that the care home could see how many packages were included for each resident, and this included a separate record for medicines that should be stored in a fridge, and controlled drugs. This helped if there were any queries from the care home.

Medicines were obtained from a range of licenced wholesalers. A random sample of dispensary stock was checked, and all the medicines were found to be in date. Date checking records were maintained, and medication was pro-actively removed prior to its expiry date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging, although some packs contained multiple batches of the same medication which could increase the chance of out-of-date medicines not being identified or recalled stock not being quarantined. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Drug recalls were received electronically and marked when they were actioned.

The controlled drug cabinets were secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

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.