General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ipharmacy Direct, 2 Raynham Street, ASHTON-UNDER-LYNE, Lancashire, OL6 9NU

Pharmacy reference: 1117249

Type of pharmacy: Closed

Date of inspection: 02/06/2021

Pharmacy context

This pharmacy is situated in a closed unit in a residential area. Members of the public do not usually visit the pharmacy in person. Instead the pharmacy delivers medicines to people in the local area. The pharmacy mainly dispenses NHS prescriptions to people in the community and in care homes. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy has a website (www.Ipharmacy.co.uk) which provides information about the pharmacy. The inspection was undertaken 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 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 not all met	4.3	Standard not met	The pharmacy does not manage and store medicines in an organised manner. It cannot provide assurance that the temperature of its medical fridges is properly monitored. Some medicines in the pharmacy are not stored in their original packaging and have not been appropriately labelled. And the pharmacy does not have a robust date checking procedure.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages risks to make sure its services are safe, but it could do more to make sure the pharmacy team learns from its mistakes. It has written procedures on keeping people's private information safe and the team understands how it can help to protect the welfare of vulnerable people. The pharmacy keeps the records required by law, but some records are not accurate, which could make it harder to understand what has happened if problems arise.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) for the services provided but there was nothing to indicate that members of the pharmacy team had read and accepted the SOPs. So, team members may not always work effectively or fully understand their roles and responsibilities and who is accountable for what. The pharmacist superintendent (SI) was working as the responsible pharmacist (RP). His name was on the RP notice, but the notice had been covered and could not be seen. This was rectified when pointed out.

The SI confirmed he had carried out individual Covid-19 staff risk assessments, but this had been in the form of a verbal discussion and nothing had been recorded. Members of the pharmacy team had been provided with face masks, which they routinely wore, and hand sanitizer was available. They had all received a covid vaccination, but they were not carrying out lateral flow testing, so any infection in the team might go undetected. The SI said he would ensure testing was taking place on a regular basis, going forward.

There was an electronic error recording system which could be used to record and review both dispensing errors and near miss incidents. No dispensing errors and only one near miss had been recorded on this system. The SI confirmed that there had not been any dispensing errors in the last year but admitted the team were not currently recording or reviewing their near miss errors. This means the team may miss learning opportunities. The SI confirmed that he would start to use the electronic recording system and record the team's learnings on it. A trainee dispenser said the SI brought any errors which he made to his attention and he felt comfortable discussing them. He said he took steps to reduce re-occurrences such as taking care to select the correct form and strength, which tended to be the most common error.

The complaints procedure and details of the local Patient Advice and Liaison Service (PALS) were available on the pharmacy's website under 'feedback'. An annual customer satisfaction survey was carried out. People using the pharmacy were sent texts with a link which allowed them to access and complete the survey. Summaries of the previous three surveys were published on the website. One of the surveys indicated that providing healthy living advice was an area requiring improvement. The SI said he gave lots of advice to people about this, but he did not usually make a record of it.

The certificate of professional indemnity insurance on display had expired. The SI confirmed that it had been renewed and he subsequently provided a current insurance certificate. Private prescription records and the RP record were appropriately maintained but the nature of the emergency was not always recorded for emergency supplies. Records of controlled drug (CD) running balances were kept,

but these were not regularly audited, so missing entries might not always be identified. The SI said they were moving to electronic CD registers and running balances would be regularly checked as part of this new system.

Confidential waste was collected in designated bins which were collected by a specialist waste disposal company. There was a work experience student working in the pharmacy. He had a basic understanding about patient confidentiality and said the SI had explained this to him when he started. The student understood the process for dealing with confidential waste. The delivery driver confirmed he had read the confidentiality SOP.

The delivery driver said he would voice any concerns regarding vulnerable adults to the SI. The SI had not completed formal training on safeguarding, but he knew he should report any safeguarding concerns. A dispenser pointed out a notice on display which had the safeguarding contact details for Greater Manchester. She described two occasions when members of the pharmacy team had contacted a patient's GP because they had safeguarding concerns about one of their patients. The SI confirmed he would complete a suitable safeguarding training course and subsequent to the inspection he forwarded certificates showing the completion of Centre for Pharmacy Postgraduate Education (CPPE) level 1 and 2 training on safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members are comfortable providing feedback to their manager and they receive informal feedback about their own performance. But they are not always effectively supported to complete training, so there may be gaps in their knowledge.

Inspector's evidence

There was a pharmacist (SI), dispenser, a trainee dispenser, a delivery driver and a work experience student on duty at the time of the inspection. The staff level was adequate for the volume of work seen during the inspection. Planned absences were organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff hours and on some days additional pharmacist cover was provided by a regular locum pharmacist, who worked alongside the SI. The work experience student was from the local college and had worked a couple of hours each week for a few weeks. The SI said he had given him some induction training, but he had not made a record of this. The SI and trainee dispenser said they supervised the student's work, but he did not have a clearly defined role and the SI had not completed an associated risk assessment. The student carried out activities such as putting away dispensary stock and assembling medicines, which he was not qualified to do, and had not received training for, so this increased the risk of errors. The SI explained that in the future he would tell the student to observe these activities rather than carrying them out himself.

The pharmacy team had informal meetings once a month where they were kept up-to-date with what was happening in the pharmacy. The trainee dispenser said he would feel comfortable talking to the SI about any concerns he might have. There was a whistleblowing policy in the SOP folder. The team had access to some online training modules, but there was no record of any completed training and staff did not have regular protected training time. The trainee dispenser was enrolled on an accredited training course, but progress through the course had been slow. Team members performance and development was discussed informally and the SI had made a few notes about their training requirements before they commenced training courses.

The SI was empowered to exercise his professional judgement and could comply with his own professional and legal obligations such as refusing to sell codeine containing medicines following requests by telephone. Staff were not under pressure to achieve targets for services such as new medicine services (NMS), as these were not completed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally safe and the pharmacy provides an adequate environment for people to receive healthcare services.

Inspector's evidence

The pharmacy premises were in an adequate state of repair. The pharmacy consisted of two dispensaries linked by a shared entrance hall which also led to an upstairs flat. The doors into the two dispensaries contained digital locks. The flat was no longer occupied, and members of the pharmacy team were the only key holders. The dispenser said the flat was going to be used as additional storage space for the pharmacy rather than for residential purposes. The temperature and lighting were adequately controlled. Maintenance problems were either dealt with by the SI or reported to the landlord. The SI said he was arranging to upgrade the flooring in the pharmacy. Staff facilities included a small kitchen area and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water.

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

Summary findings

The pharmacy provides a small range of healthcare services which are generally well managed. It gets its medicines from licensed suppliers, but it does not always store medicines in an organised manner, and it cannot show that it stores medicines requiring refrigeration at the correct temperature.

Inspector's evidence

The pharmacy was not open to the public. Patients could communicate with the pharmacy team via the telephone or by e-mail. There was a pharmacy website which provided some information about the pharmacy and the services it provided, but it did not contain the pharmacy's registration number or the name and registration number of the SI, so people might not be able to easily find this information. There was some signposting information on display in the dispensary which could be used to inform people of services and support available elsewhere. Some members of the pharmacy team were multilingual speaking Urdu and Punjabi, which assisted some of the non-English speaking members of the community.

Over-the-counter (OTC) medicines were not available for purchase via the website. Customers wishing to purchase medicines discussed their request with the pharmacist over the telephone. Records of sales were not recorded for each customer so patterns could not be monitored. The SI explained that they did not sell many OTC medicines, and they did not sell medicines which could be abused such as codeine containing products. There was a home delivery service with associated audit trail. The service had been adapted to minimise contact with recipients, in light of the pandemic. The delivery driver stayed a safe distance away whilst the prescription was retrieved from the door-step, and then confirmed the safe receipt in their records. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

The team were aware of the valproate pregnancy prevention programme. Regular patients in the at-risk group had been identified and the SI checked that that they were aware of the importance of pregnancy prevention. The valproate care cards were available on medication packaging to ensure people in the at-risk group were given the appropriate information and counselling, and the team were aware that additional cards could be printed off if necessary.

The pharmacy supplied around 70 community patients and 70 care home patients with their medicines in compliance-aid packs. The SI demonstrated that changes to medication supplied in these packs was confirmed with the prescriber and this was recorded on the patient medication record (PMR) system. There was no dispensing audit trail for community compliance-aid packs, so it was not clear who had assembled and checked them which might limit learning in the event of a mistake. Medicine descriptions were usually included on the labels to enable identification of the individual medicines. Care home patients received their medication in single dose packs. Packaging leaflets were not usually included, so people might not have easy access to all of the information they need to take their medicines safely. Disposable equipment was used.

The pharmacy was reasonably spacious, but the dispensary shelves were untidy and the working areas were cluttered and disorganised, which could increase the risk of error. Patient returned medicines

were not clearly separated from current stock. Baskets were available for dispensing to help separate prescriptions and improve the organisation in the dispensary, but these were not consistently used.

CDs were stored in a CD cabinet which was securely bolted to the wall. Date expired, and patient returned CDs were stored securely but they were not clearly labelled and segregated, so might be confused with current stock. Denaturing kits were available to destroy patient returned CDs.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. The trainee dispenser said date checking was carried out, but it was not documented and he could not recall which part of the dispensary had been recently checked. So some parts of the dispensary might not be date checked on a regular basis, increasing the risk of an out-of-date medicine being supplied. Pharmaceutical waste bins were available for the storage of obsolete medicines, but there was also a large amount of patient returned medicines in plastic tote trays. Some of these medicines had the previous patient's medication labels removed, so they might be confused for stock. The trainee dispenser confirmed that these medicines would not be re-used. There was a large number of loose foils containing tablets which were stored outside of labelling regulations with no indication of their expiry date or batch number. The SI said they would not be used and he would make sure they were removed from the shelves and placed in pharmaceutical waste bins.

There were two medical fridges. The minimum and maximum temperatures of one of the fridges had been recorded daily and was within range at the inspection. The other medical fridge was within range during the inspection, but the thermometer was recording a maximum temperature of 18 degrees Celsius, and its temperature had not been regularly monitored. The dispenser said this was because she did not know how to read the thermometer or how to reset it. So, there was a risk that medicines stored in this fridge might not be stored at the correct temperature. There was a small fridge in the second dispensary which was labelled for staff use. The temperature was not monitored but it contained some packs of insulin. The SI said this had been returned by the driver and was to be destroyed, although it did not contain medication labels, so could easily be confused with current stock.

Alerts and recalls were received from the Medicines and Healthcare products and Regulatory Agency (MHRA) and were printed off. The action taken was not always recorded so the pharmacy might not be able to demonstrate this if a query arose. The pharmacy's new electronic reporting system provided alerts. There was a facility to record the action taken and the SI said he would use this system going forward.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide.

Inspector's evidence

The pharmacy team could access the internet for the most up-to-date information. The SI used his mobile phone to access the electronic British National Formulary (BNF) as the most recent BNF was not available in the pharmacy in printed form. A current version of the children's BNF was available. There was a small selection of glass liquid measures with British standard and crown marks. The pharmacy also had equipment for counting loose tablets and capsules. There was a separate tablet triangle that was used for cytotoxic drugs. Medicine containers were stored with their caps on to reduce the risk of contamination. Electrical equipment appeared to be in working order. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy so staff could move to a private area if the phone call warranted privacy.

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.