General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: My Doctors Chemist, Units D And C2, Phoenix Mill, Estover Road, PLYMOUTH, PL6 7PY

Pharmacy reference: 1125045

Type of pharmacy: Closed

Date of inspection: 21/10/2024

Pharmacy context

The pharmacy is located on a business park in Plymouth. It is a distance-selling pharmacy and is closed to the public. The pharmacy dispenses NHS prescriptions and delivers them to people's homes. It also dispenses medicines to the residents of care homes. It can also dispense private prescriptions. The pharmacy dispenses medicines into multi-compartment compliance aids to help people remember to take them. The pharmacy also carries out a limited range of NHS services including the New Medicines Service and the Discharge Medicines Service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	1.8	Good practice	Pharmacy team members know how to protect the safety of vulnerable people and take prompt action to raise safeguarding concerns.
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 provides its services safely and effectively. It has suitable systems in place to identify and manage the risks associated with its services. Team members record any mistakes they make and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. And these procedures are reviewed and updated regularly. The pharmacy asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's private information safe. Pharmacy team members know how to protect the safety of vulnerable people and take prompt action to raise safeguarding concerns.

Inspector's evidence

The pharmacy was a distance-selling pharmacy and was closed to the public. Its main activity was the dispensing and delivery of medicines to people living at home and to the residents of number of care homes. The pharmacy also dispensed medicines into multi-compartment compliance aids for a large number of people. The pharmacy had processes in place to manage and reduce its risks. It had standard operating procedures (SOPs) which covered all its activities. The SOPs were currently held on an online system, PharmSmart, and they had been read by all team members. The superintendent pharmacist (SI) was currently implementing new SOPs which more closely reflected how the pharmacy operated. The pharmacy team could describe the activities that could not be undertaken in the absence of the responsible pharmacist (RP). Team members had clear lines of accountabilities and were clear on their job role. The pharmacy had risk assessments in place to cover its activities. And it had a written business continuity plan.

Team members made a record of mistakes they made when dispensing which were picked up in the final accuracy check, known as near-misses, on an online reporting system. The SI said that not all near-misses were reported due to time constraints. But the pharmacy team discussed all mistakes and tried to learn from them. The entries that were in the near miss log contained a brief reflection on why the error occurred and actions taken to prevent a reoccurrence. Any errors that reached the patient were reported in a more detailed way. The SI reviewed the errors every month when completing a patient safety review. The outcome of the review was shared with the pharmacy team, who put actions in place to reduce the likelihood of errors happening again. For example, medicines that looked or sounded alike which had been incorrectly dispensed had been separated from each other. And stickers advising caution were applied to shelf edges.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. There was a rota in place for team members to answer telephone calls, which was how most feedback was received. Any complaints were passed straight to the SI to deal with. The SI made sure to pass any compliments received to the team. A complaints procedure was available on the pharmacy's website. Public liability and professional indemnity insurance were provided by the NPA.

The pharmacy kept a record of who had acted as the RP each day. The correct RP notice was prominently displayed. Controlled drug (CD) registers were in order. Balance checks were completed regularly and any discrepancies were promptly rectified. A random balance check was accurate. Patient

returned CDs were recorded in a separate register and were stored in the CD cabinet. They were destroyed promptly. The pharmacy occasionally dispensed private prescriptions and made appropriate records in a book. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials'). Certificates of conformity were stored with all required details completed.

The pharmacy took steps to protect people's personal information. This included segregating confidential information and disposing of it appropriately. No members of the public entered the pharmacy so confidential information was well protected. When answering queries on the telephone, team members took care not to disclose any confidential information if not talking to the patient. Team members used their own NHS smart cards.

All team members were trained to an appropriate level on safeguarding. The SI had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 3 safeguarding training and certificates were available. The pharmacy team were aware of signs to look out for that may require a safeguarding referral. The pharmacy up to date contact details of local safeguarding and support agencies. And further information could be accessed on the internet. The delivery drivers had completed learning on protecting vulnerable people. The SI gave multiple examples of when they had raised concerns about people to whom medicines were delivered to protect their safety.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs enough people to manage its workload. Team members are trained to deliver their roles and keep their skills up to date by completing regular learning activities. They are confident to suggest and make changes to the way they work to improve their services. Team members communicate effectively and support each other well. And they work well together to deliver the pharmacy's services.

Inspector's evidence

The SI worked full time in the pharmacy as the responsible pharmacist (RP). A second pharmacist provided additional support on a part-time basis. There were two pharmacy technicians, one of whom was an accuracy checker. There were also three fully-trained dispensers and one trainee dispenser. The pharmacy also employed four full-time delivery drivers.

The pharmacy team were coping with the workload well and dispensing was up to date. It was clear that the team worked well together and supported each other. They had a good rapport and knew their roles and responsibilities well.

The team were encouraged to discuss concerns and give feedback to the SI. Team members were confident to make suggestions for changes which would improve how the pharmacy operated. Team members were aware of the internal escalation process for concerns and a whistleblowing policy was in place.

Team members were given time during working hours to learn. They had recently learned together as a team how to operate a new patient medication record system. The SI encourage team members to undertake courses to achieve additional qualifications. For example, a dispenser was soon to register on the training to become a pharmacy technician. The pharmacy team encouraged each other to learn and helped each other. The trainee dispenser was working through a planned induction programme. They were given plenty of time to learn at work and they were able to ask questions of the pharmacist. Each team member had regular appraisals where they could discuss their progress.

The pharmacists used their clinical judgement and ensured all services provided by the pharmacy were appropriate for the person requesting them. There were no targets or incentives set.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver its services from. And it is clean, secure and appropriately maintained.

Inspector's evidence

The pharmacy was located on an industrial estate in Plymouth, Devon. It was closed to the public and people wishing to enter the pharmacy used a doorbell. On the ground floor was a large room where completed prescriptions awaiting delivery were stored. This room also housed medicines disposal bins and patient-returned medicines which were waiting to be disposed of. There was also a consultation room on the ground floor. Whilst it was not regularly used, it was well equipped and presented a professional image. It had plenty of space for people using wheelchairs or mobility scooters. There was a clean sink.

On the first floor, there was a large dispensary and offices. The dispensary was separated into distinct areas where different activities took place. Multi-compartment compliance aids were dispensed and checked at one end of the dispensary. And medicines going to care homes were dispensed at the other. There were also spaces to dispense medicines being delivered to people in their own homes. The dispensary was very well organised. Stock was stored neatly on shelves around the perimeter of the dispensary.

The pharmacy was regularly cleaned and a cleaning rota was displayed. There was no clutter and it was a professional environment. Lighting was appropriate and the temperature was satisfactory for the provision of healthcare and the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services appropriately. And it supplies medicines safely, ensuring appropriate advice is given. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes checks to ensure that they are still suitable for supply. The pharmacy delivers medicines to people safely and keeps appropriate records of this. The pharmacy accepts unwanted medicines and disposes of them appropriately.

Inspector's evidence

The pharmacy was closed to the public. It had a website which clearly displayed the telephone number and email address. The website displayed information about currently public health campaigns. The pharmacy could make adjustments for people with disabilities, including producing large print labels. If the pharmacy was contacted by someone looking to purchase an over-the-counter medicine, they were referred to the nearest pharmacy that was open to the public. Up-to-date signposting resources and details of local support agencies were accessed online.

The pharmacy had a clear and organised workflow. Team members dispensed each person's prescription into separate baskets to prevent transfer between patients as well as to organise the workload. Team members initialled the dispensing labels to show who had completed each stage of the process.

The pharmacy used stickers to identify prescriptions that contained CDs, fridge items and high-risk medicines. The pharmacy took extra care to ensure that high-risk medicines were supplied safely. The pharmacists ensured that alert and warning cards were issued with high-risk medicines. And they spoke to the person prescribed them on the telephone if they felt additional advice was warranted. The pharmacy kept records of significant interventions on the person's medication record.

The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate and topiramate as part of the Pregnancy Prevention Programme (PPP). The pharmacy team took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. They were aware of the recent updates to guidance about supplying valproate safely to those who had the potential to become pregnant whilst taking it. The pharmacists had regular conversations with the people at risk who were prescribed valproate to ensure they were on adequate contraception. And records were made on the PMR.

The pharmacy served a lot of care homes. They dispensed medicines in original packs or into multi-compartment compliance aids depending on the care homes preference. The pharmacy supplied medication administration record (MAR) sheets to care homes alongside dispensed medicines. The pharmacy used two different systems to supply MAR sheets, depending on the care home's preference. One system was electronic and the other was paper-based. The MAR sheet often included a photograph of the resident which was used by care home team members to check that they were administering to the correct person. The process used by the pharmacy and the care homes to request and order prescriptions was robust. The monthly orders were usually ready well in advance of the delivery date. And urgent prescriptions were usually delivered on the same day.

The pharmacy prepared a large number of multi-compartment compliance aids. The workload was organised and well planned. A sample of compliance aids was inspected. Each compliance aid was clearly labelled and contained a description of the tablets included so that they could be easily identified. Patient information leaflets (PILs) were supplied each month. 'When required' medicines were dispensed in boxes and team members were aware of what could and could not be placed in trays. A record of any changes made was kept on a patient information sheet, which was available for the pharmacist during the clinical checking process.

The dispensary shelves used to store stock were organised and tidy. The stock was mostly arranged alphabetically. The pharmacy team date-checked the stock regularly and records were kept. The team maintained a written list of medicines due to expire in the near future and this was cross-referenced at the end of each month. No date-expired medicines or mixed batches were seen on the shelves. The pharmacy managed prescriptions containing owings appropriately and the prescription was kept with the balance until it was completed. The pharmacy obtained stock from reputable sources. The pharmacy was signed up to receive recalls and alerts by email. And records were kept of those received and the action taken.

The fridge in the dispensary was clean, tidy and well organised. Records of temperatures were maintained. The maximum and minimum temperatures were within the required range of 2 to 8 degrees Celsius. CDs were stored in accordance with legal requirements. The pharmacy had a supply of denaturing kits for the safe destruction of CDs. Patient returned CDs were recorded in a register and destroyed promptly.

The pharmacy kept a record of the deliveries it made. People receiving deliveries of medicines signed a delivery sheet to confirm receipt. The delivery driver kept a cool bag in the van to ensure medicines requiring refrigeration were kept cold. Patient returned medication was dealt with appropriately. Patient details were removed from returned medicines to protect people's confidentiality.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses appropriate equipment and facilities to provide its services. It keeps these clean and tidy. The pharmacy uses its equipment in a way that protects people's private information.

Inspector's evidence

Measuring cylinders meeting the International Standard were available for liquids. One was reserved solely for the measuring of CDs. A range of clean tablet and capsule counters were present. One was clearly marked as being for the counting of cytotoxic medicines only. All equipment, including the dispensary fridges, was in good working order and PAT test stickers were visible. The sink was clean and in good working order.

Reference sources including the British National Formulary were available and the pharmacy could also access up-to-date information on the internet. Access to the pharmacy computers and PMR system was password protected. The pharmacy segregated confidential waste and regularly shredded it to protect people's private information.

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.