General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Clovelly Pharmacy, 1 Northfield Road, DEWSBURY, West Yorkshire, WF13 2JX

Pharmacy reference: 1126325

Type of pharmacy: Internet / distance selling

Date of inspection: 08/05/2019

Pharmacy context

This is a pharmacy which offers its services to people at a distance through its website and by telephone. The pharmacy dispenses NHS and private prescriptions. There is no public access to the pharmacy premises. People receive their medicines by delivery. The pharmacy also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 has adequate processes and procedures, so the team can manage the risks to its services. It keeps the records it must by law. People can contact the pharmacy to provide feedback on its services. But the pharmacy doesn't advertise how to make a complaint. So, people may be unsure of the process. The team cannot demonstrate how they have used feedback to improve its services. The pharmacy keeps people's private information safe. All the team members complete training so they know how to protect the welfare of children and vulnerable adults. The pharmacy's team members record errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy had an electronic set of standard operating procedures (SOPs) in place. All team members had read and signed the SOPs relevant to their role. The SOPs were prepared in March 2015. The most recent review was recorded as due in March 2017 and so they were past their review date. This means there is a risk that pharmacy procedures may not be up-to-date. The SOPs contained sections to be filled with who was responsible for performing each task. But these sections were incomplete.

The pharmacy offered medicines for sale through its website. The orders were fulfilled by a third-party registered pharmacy. The pharmacy's website displayed the mandatory European common logo on each page, denoting MHRA registration for selling medicines. Clicking on the logo provided details of the third-party pharmacy fulfilling the orders. The pharmacy owner explained that the website should sell over-the-counter medicines only. But a section labelled 'Vet Prescriptions' allowed people to add prescription only medicines to their basket, including some schedule 3 controlled drugs. The owner stated that he was not aware that these medicines were for sale. The pharmacy had no regular monitoring processes in place for the website. The team were not aware of the new guidance published by the GPhC relating to registered pharmacies providing services at a distance, including over the internet. The guidance included safeguards relating to pharmacies supplying prescription-only medicines (POMs) over the internet. The owner contacted the inspector shortly after the inspection to confirm that the pharmacy had removed the advertisement for veterinary POMs from its website. A check of the website confirmed this.

The pharmacy had a process in place to report and record near misses. The pharmacist typically spotted the error and then let the team member know that they had made an error. The team member identified what had happened to help them reflect on why it occurred and to help with their learning. The team members were encouraged to record details of their own errors on to a log. But the pharmacist often made the record. The records included the time and date of the error. But the team didn't regularly record the causes of the errors. The near miss logs were informally analysed every two months. This was done to see if there were any patterns or common trends. The team had recently separated amlodipine 10mg and 5mg tablets as they were similar in appearance. The pharmacy recorded details of dispensing incidents and kept the records for future reference. The pharmacy had recently made an error where they supplied E45 itch relief cream instead of E45 cream. The team

separated these two items to prevent the error happening again.

A complaints section sub-menu was available on the pharmacy website. But the section had a basic message which read ‘coming soon’. The pharmacy’s contact details were clearly displayed on the website and the team members advised that people could use the contact details to make any complaints.

The pharmacy asked people to complete a questionnaire each year. This was designed to tell the pharmacy what they were doing well and where people thought they could improve. The results for the 2018 survey were displayed on the pharmacy’s website. The results were generally positive. The main area for improvement was ‘Providing advice on physical exercise’. But the team could not demonstrate what steps they had taken to improve.

The pharmacy had up to date insurance arrangements in place.

The pharmacy used a book to record private prescription supplies. And from the sample checked, the records were complete and accurate. The responsible pharmacist register was complete and a responsible pharmacist notice was on display. The pharmacy did not make any emergency supplies or made any supplies of unlicensed medicines.

A sample of controlled drug (CD) registers were looked at and were in order. They included completed headers. And entries were in chronological order. Running balances were maintained. And they were generally checked every two to three months. But the last recorded check for Zomorph 60mg capsules was December 2018. A random CD item was balance checked and verified with the running balance in the register (Medikinet 10mg X 14). The pharmacy correctly completed a CD destruction register for patient returned medicines.

Confidential waste was placed into a separate bin to avoid a mix up with general waste. The team periodically destroyed the confidential waste using a shredder. A privacy policy was displayed on the pharmacy's website.

Three regular pharmacists and a pharmacy assistant had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) on safeguarding the welfare of vulnerable people. The team members gave several examples of symptoms that would raise their concerns. And they kept an electronic file containing the contact details of key safeguarding leads. And they had a safeguarding incident handbook. All team members including the delivery driver had read the policy. The owner was keen to ensure that the driver was aware of any signs of vulnerability of people he delivered medicines to. He informed the inspector that the driver had recently made him aware of a person who was not taking his medicines as prescribed. The driver raised the issue with the pharmacist on duty. And the concern was escalated to the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to their own needs.

Inspector's evidence

At the time of the inspection the responsible pharmacist was a locum pharmacist. And was employed to work every Wednesday. The owner was providing support as the main NVQ3 qualified dispenser was absent. The pharmacy employed a regular pharmacist who worked two to three days a week with the remaining days being covered by locum pharmacists, the owner or the superintendent pharmacist. The pharmacy also employed a part-time dispenser who was asked to cover planned and unplanned absences.

The pharmacy did not provide its team members with a structured process for ongoing learning. But it supported the team members to undertake training by giving them time to read trade press material sent to the pharmacy. The team members were able to tailor their learning to their needs.

The team members regularly shared feedback about near misses and various patient safety issues with each other. They were open and honest about their mistakes and discussed them in open conversations which involved all team members that were present at the time. The team members had recently attended a team meeting to discuss medicines that looked and sounded alike. The purpose of the meeting was to raise awareness and to reduce the risk of selection errors with these medicines.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required. The pharmacy did not set the team any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and generally clean and well maintained. The premises are suitable for the services provided.

Inspector's evidence

The premises consisted of a large dispensary and staff amenities. The pharmacy was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services to help people meet their health needs. It stores, sources and manages its medicines safely. The pharmacy supplies some people's medicines in multi-compartmental compliance packs. And it identifies and manages risks associated with the service. The pharmacy delivers medicines to people. But the pharmacy doesn't require people to sign to confirm that they have successfully received their medicines. And so, the pharmacy may find it difficult to resolve any queries or identify any errors, relating to the service.

Inspector's evidence

The pharmacy's website had a 'contact us' section. It displayed the pharmacy's address and telephone number. The pharmacy's opening hours were also displayed. People could send queries to the pharmacy by completing an online form. The website had a 'health advice' section which gave brief information about various conditions for example, hay fever and migraine.

During dispensing the team members recorded notes on prescriptions to alert them to complete various actions later in the process. For example, to highlight interactions between medicines or the presence of a fridge or a controlled drug that needed to be added to the bag. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The dispensary had a manageable workflow. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. And they used baskets to keep prescriptions and medicines together. This helped prevent people’s prescriptions from getting mixed up.

The pharmacy did not have any procedures in place to identify and monitor people on high-risk medicines such as warfarin. The pharmacy owner reported that this was because of the minimal face-to-face contact they had with the people who used the pharmacy. There was a discussion during the inspection regarding requirements to manage risks. The pharmacy owner said he recorded any significant events that he was made aware of. Such as changes in a person’s INR levels. The team members knew about the pregnancy prevention programme for people who may become pregnant who were prescribed valproate. And they knew about the risks and demonstrated the advice they would give people in a hypothetical situation. But they did not have access to any literature about the programme. So, they couldn't send out any written information on delivery with the medicines, if they needed to. The pharmacist said the team did not regularly dispense any prescriptions for valproate for people in the 'at risk' group.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team members ordered the person's prescription about a week in advance, so they had ample time to manage any queries. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. And they checked with people before they ordered, if they required any items that they didn't supply in the packs. Team members recorded details of any changes, such as dosage increases and decreases. And they clearly labelled the packs with dosage instructions, warnings and the person's details. But they did

not always include descriptions of the medicines inside the pack. Team members supplied patient information leaflets with the packs.

The pharmacy kept basic records of the delivery of medicines from the pharmacy to people. The records did not include a signature of receipt, unless the medicine delivered was a CD. The pharmacy supplied people with a note when a delivery could not be completed advising them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity.

The team members checked the expiry dates of the stock ad-hoc. No out of date stock was found. And they kept records of the activity. They used stickers to highlight medicines that were expiring in the next 6 months. They recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And to check that they were fit for purpose and safe to supply to people. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software, scanners or a SOP available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

The medicines inside were well organised. The team used digital thermometers to record fridge temperatures each day. A sample of the records were looked at and the temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them immediately. The team members printed the alerts and stored them in a folder. They kept a record of the action they took following the recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. And it keeps its equipment clean and secure.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs.

The medical fridge was of an appropriate size. The medicines inside were well organised.

The computers were password protected and access to people's records were restricted by the NHS smart card system.

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.