General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Victory Internet Pharmacy, 2 Fairway Business Centre, Airport Service Road, Portsmouth, Hampshire, PO3 5NU

Pharmacy reference: 9010405

Type of pharmacy: Internet / distance selling

Date of inspection: 30/08/2023

Pharmacy context

This is a 'distance selling pharmacy' on Portsmouth's airport industrial estate. People can't visit the pharmacy in person, so it provides its services remotely. It dispenses people's prescriptions and delivers them to addresses across Hampshire, from Andover in the west to Emsworth in the east. It has its own website and facebook page.

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	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 provides its services in line with clear, written instructions which its team members follow when completing their tasks. Its team members work to professional standards, they are clear about their responsibilities and know when to seek help. The pharmacy keeps satisfactory records of the mistakes that occur. The superintendent pharmacist regularly reviews them with members of the team so that they can all learn from them and help prevent them from happening again. The pharmacy keeps appropriate records as required by law. Its team members have a satisfactory understanding of their role in helping to protect vulnerable people. They manage and protect people's private information well.

Inspector's evidence

There were standard operating procedures (SOPs) which covered the activities carried out by the team. They were created in 2016 and were currently undergoing a full review. Team members had signed the SOPs to confirm that they had read and understood them, and a quiz was held on a regular basis to test their knowledge. A few team members were still yet to sign them. The owner, who was also the pharmacy manager, agreed to ensure the remaining team members read and signed them as soon as possible. There was a business continuity plan in place so that the pharmacy could continue to provide its services in the event of a power cut or similar unforeseen emergency. The pharmacy manager confirmed that he maintained this as part of the NHS pharmacy quality scheme (PQS).

There were near miss record sheets, which identified those mistakes which had been corrected before leaving the premises. They showed who had made the mistake, when it occurred, details of the error and the category it fell under. Although the sheets themselves didn't show evidence of any reflection or corrective action, these mistakes were discussed in the monthly team meetings. The notes of those meetings did contain details of the possible causes and the actions taken to help prevent a recurrence. The meeting notes themselves didn't show who had attended the meetings, but everyone was also kept up to date via a 'whatsapp' group for all its team members. The pharmacy manager or the superintendent pharmacist (SI) used this to ensure everyone had been included. Dispensing errors which had been identified after they had left the premises were also discussed in these meetings. They were recorded on the NHS 'learning from patient safety events service' (LFPSE) website once the potential cause(s) had been identified and corrective action taken. The pharmacy manager described one incident where they had changed their procedures and updated the relevant SOP as a result.

The pharmacy manager explained that everyone's job description set out their responsibilities, so that between those and the SOPs, it was clear what each team member could and could not do. There was a responsible pharmacist (RP) notice on display by the pharmacy's admin desks. The RP records were maintained on the pharmacy's computer system. Those records examined were all complete and in order. All dispensing labels were initialled to show who had assembled prescriptions and who had checked them. Prescriptions were all marked with a quad stamp, initialled to show who had labelled them and who had completed the clinical check.

The pharmacy monitored its facebook page and accepted feedback from people online. It had responded to some feedback about its repeat prescription process by further clarifying whether people wanted the pharmacy to manage their reordering or not. There was a current certificate of insurance

on display showing that the pharmacy had professional indemnity cover in place until August 2024.

Private prescriptions were recorded in the private prescription register. Those entries examined were all in order. Emergency supplies were generally made through the NHS111 service and recorded on the PharmOutcomes online platform. The emergency supply records examined did not include much detail of the reason for the supply. Upon reflection both the RP and the pharmacy manager agreed to include more detail in future. However, the RP was able to show an example of a supply which had been refused, where clear reasons for the refusal had been recorded. Records of unlicensed medicines ('specials') were complete, including the necessary details on the certificates of conformity. Those electronic controlled drug (CD) records examined were in order, with stock balances being checked every Monday. There were a small number of amended entries, such as when a quantity had been entered incorrectly. Those amendments included a record of who had made the change, when it was made and the reason for doing so. Two CDs selected at random were checked and their stock balances were found to correspond with their respective entries in the register. All delivery notes or invoices for CDs were initialled by the pharmacist to confirm that they had been entered into the CD register. They were then stored separately from other invoices for easy access if there was a query in the future. The pharmacy's patient medication record (PMR) system was backed up regularly to secure cloud storage.

There was an information governance (IG) policy in place, and a privacy notice on the pharmacy's website. There was also a notice on display showing details of the pharmacy's registration with the Information Commissioner's Office (ICO). The data security and protection (DSP) toolkit had been completed and submitted in accordance with NHS requirements. Those team members present understood the UK general data protection requirements (GDPR) and knew how to protect people's private information. Confidential waste was segregated from other waste, secured in sacks and collected every six weeks for secure destruction by a licensed waste contractor. The pharmacy's delivery drivers used an app to track their deliveries without disclosing one person's private information to another.

Team members were aware of their role in safeguarding people who may be vulnerable. There was a process in place to escalate any concerns and contact the appropriate agency if support or advice was needed. Contact details of the local safeguarding agencies were on a notice by the main admin desk. An example of safeguarding was given but no record had been made. All registrants had completed level two safeguarding training, one of whom had also completed level three.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has plenty of staff to manage its workload safely, and they work well together as a team. The pharmacy provides its team members with regular training to help keep their knowledge up to date. And it keeps suitable records to help them with their development. It also ensures they can make suggestions to improve safety and workflows where appropriate.

Inspector's evidence

There were two full-time trainee dispensing assistants, three full-time qualified dispensing assistants, one full-time registered accuracy checking technician (ACT), one part-time dispensing assistant who was also a delivery driver, the owner (pharmacy manager) and the RP on duty at the time of the inspection. They appeared to be working well together and managing their workload. The pharmacy manager confirmed that the staffing levels were kept under constant review to ensure that the pharmacy operated safely.

Staff training records were kept along with any certificates of achievement. Training needs were identified by the pharmacy manager and superintendent pharmacist in line with PQS requirements. And team members were also able to identify their own training needs. Some examples of recent training that the team had completed were dementia training and asthma awareness. Team members did not have a formal appraisal but felt comfortable enough to feedback ideas and concerns to the pharmacy manager. Two team members were currently undertaking a dispensing training course and had infrequent reviews with the pharmacy manager to assess their progress. A development plan was available to document this. There were no specific targets for individual team members so had no impact upon their professional decision making.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are spacious and provide an appropriate environment for the service it provides. They are suitably laid out so that team members have sufficient space to work effectively and safely. The premises are secure so that other people can't enter them without the team's knowledge.

Inspector's evidence

The pharmacy premises were in a warehouse building with two floors. The entrance door was locked and people wanting to enter had to wait to be let in. There was a small lobby with a flight of stairs to the first floor, and a door to the right leading to the main dispensing area. There were tote boxes in the lobby awaiting collection by the pharmacy's wholesalers. At the front of the ground floor were the pharmacy's admin desks where the owner and another team member took phone calls, organised the day's deliveries and generally oversaw the operation. There were plenty of workbenches around the perimeter and two large island workstations in the middle of the room. The pharmacy appeared to be well laid out, clean and tidy with some baskets of prescriptions currently being assembled or checked. There was a sink, which was clean and supplied with hot and cold running water.

The first floor had a second smaller dispensing area, as well as an office and seating for the team to use while on their breaks. There were combined heating and air-conditioning units to keep the room temperatures comfortable for people to work in and suitable for the storage of medicines.

The pharmacy's website (https://victoryinternetpharmacy.co.uk) contained the required information about the pharmacy and its superintendent pharmacist. The main focus appeared to be on encouraging people to use it for their NHS prescriptions and the pharmacy's delivery service. There was also detailed information on a range of medicines and conditions that had been sourced from the NHS.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its service in a safe and effective manner. It sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. Its team members have an adequate understanding of what they need to do when supplying people with high-risk medicines. The pharmacy responds appropriately to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. And it generally manages its other services well, keeping satisfactory records so that it can show who has done what and when.

Inspector's evidence

The pharmacy was offering its services at a distance as it was not open for people to visit in person. It encouraged them to sign up online so that their NHS prescriptions could be sent directly from their doctor to the pharmacy and then delivered to them. Prescriptions were generally labelled and then clinically checked by the pharmacist before being assembled by the team. There was a quad stamp for team members to initial when they had completed those tasks. The dispensing labels were initialled to show who had assembled them and who had completed the final accuracy check. They had a system for recording what they owed to people if they were unable to supply the full amount on their prescription. One of the dispensing assistants explained that they had good working relationships with the local surgeries and that they could normally obtain prescriptions for suitable alternative products if necessary. There was also a record kept on the pharmacy's computer system of all the alternative medicines that had been agreed with the various GP practices locally.

Deliveries were completed by four part-time drivers, who used an app to record their deliveries. One of the dispensing assistants demonstrated how the app worked, and how they allocated each bag to a specific delivery run depending upon the destination. CDs prescriptions were attached to the bags so that they were easily identifiable to the drivers. They then detached the prescriptions and placed them in a designated basket so that any necessary register entries could be made. The pharmacy provided each driver with a phone with their own login details. The app on the phone highlighted the CD deliveries. It also highlighted items that needed refrigeration. There were coolbags and coolblocks to help maintain the cold chain between the pharmacy and the medicine's final destination.

The pharmacy team dispensed medicines into multi-compartment compliance packs for those people who might otherwise struggle to manage their medicines. Prescriptions were ordered by one of the team members, usually three weeks in advance of their delivery date. Once the prescriptions had been sent to the pharmacy, the team checked the medicines against the patient record to make sure it was all correct. The pharmacy kept a record for each person, which included details of their medicines, the times they took them and a record of any changes that had been made to their treatment. Those changes were also recorded on the patient medication record (PMR) system. Team members selected the medicines for the compliance aids before labelling and printing the backing sheet so that they could update the product description if necessary. This ensured that the compliance packs had accurate descriptions of the medicines inside, making it easier for people to identify them. A random selection of compliance packs was checked, and they had both the 'dispensed by' and 'checked by' boxes signed to show who had completed those tasks. But patient information leaflets (PILs) were not being supplied. Team members were reminded of the requirement to include PILs with each supply. Upon reflection the pharmacy manager agreed to include them in future. There was a full audit trail to show who had

ordered the prescriptions, dispensed them, and carried out the clinical and accuracy checks. These records were kept in case any queries should arise in the future. One member of the team de-blistered medicines into bulk containers under the direct supervision of a trained dispenser who kept a full audit trail of the medicines that went through this process. The bulk containers included batch numbers and expiry dates. There was a system in place to avoid having mixed batches.

The RP and other team members questioned were all aware of the need to check that women and girls who could become pregnant had long-term contraception in place as part of the pregnancy prevention programme (PPP). They hadn't been supplying valproates to anyone in the at-risk group at their previous audit, but upon reflection the manager and the RP agreed to review the current situation. They were also advised to check the relevant manufacturers' websites or contact their pharmacy membership organisation for the most up-to-date advice regarding these products. They did confirm that all high-risk medicines were double checked before being supplied.

The pharmacy provided the NHS New Medicines Service (NMS) remotely. The pharmacy manager outlined the process and explained how he identified any risks involved and the actions taken to manage them. For example, the pharmacist making the calls had to ensure they were made in private and that the laptop used was secure. The PMR system incorporated the required secure connection. There was a systematic plan to complete the required calls and detailed records of each intervention.

The pharmacy used recognised pharmaceutical wholesalers to obtain its stock, including its unlicensed 'specials'. There was a date-checking file with a matrix to show when each section of the pharmacy had been checked. This was carried out every three months and any stock within two months of its expiry date was identified with a rubber band so that it was easily identifiable. Team members checked that the packs would remain in date for the full duration of the prescription before using them. Opened bottles of liquid medicines had not been marked with the date of opening. When this was pointed out the pharmacy manager agreed to ensure that this would be done in future. There was also a fridge temperature chart showing their daily temperature checks, which were all within the required range. The manager explained that if they did go out of range, they would reset the thermometer and monitor the temperature more frequently until it returned within the required range.

The pharmacy's online CD register included a module to record CDs that were no longer wanted by people and had been returned to the pharmacy for denaturing and safe disposal. The records showed that six CDs had been returned since the previous April and were still awaiting destruction. Upon reflection, the manager and RP agreed to make the necessary arrangements for them to be denatured and safely disposed of. There were some denaturing kits available for this. There was also one in the CD cabinet that had been used and was sufficiently solidified for it to be disposed of. There was another that had only partially denatured so the manager and RP agreed that they needed to denature it properly so that it could be disposed of safely. They received alerts and recalls from the MHRA and could show what action they had taken where it had been necessary.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mostly has the necessary equipment for the services it provides. It also has easy access to appropriate sources of information that it may need. It uses its facilities and equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had a set of calibrated conical measures for use with liquid medicines. The pharmacy also had the necessary equipment for counting loose tablets and capsules with separate ones for cytotoxic or cytostatic medicines. It had access to online reference sources including the BNF and medicines.org. There was a new medical fridge used for storing medicines that needed to be kept between two and eight degrees Celsius. There was some condensation at the back of the refrigerator, so the team was advised to ensure that bags or boxes of medicines were pulled forwards so that air could circulate more freely inside and that they wouldn't become damp. There was also a CD cabinet which had been bolted to the floor away from any external walls. Computer screens were only visible to those working in the pharmacy, and access was controlled by individual logins and NHS smartcards.

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.