General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Corner Online, 2 Airlie Avenue, Leeds, West Yorkshire, LS8 4JL

Pharmacy reference: 9010530

Type of pharmacy: Internet / distance selling

Date of inspection: 07/06/2019

Pharmacy context

The pharmacy provides dispensing services at a distance which means people cannot access the pharmacy premises. People can access the pharmacy website and contact the pharmacy by telephone. It dispenses NHS prescriptions. And it requests prescriptions on behalf of people and delivers people's medicines to their homes.

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 identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has appropriate arrangements to protect people's private information. The pharmacy team members respond well when errors happen and act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team acts in response to feedback to improve the delivery of pharmacy services. The team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy has written procedures that the team follows. But not all the team members have signed to say they have read the procedures. This means there is a risk they may not understand or follow correct procedures.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Most of the team had read and signed the SOPs signature sheets to show they understood and would follow them. The delivery driver had not signed the SOPs relevant to their role. The pharmacy had indemnity insurance with an expiry date of 28 February 2020.

The pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. The pharmacy kept records of these errors. A sample of the error records looked at found that the team members usually recorded details of what had been prescribed and dispensed to spot patterns. And they recorded what caused the error, their learning from it and actions they had taken to prevent the error happening again. For example, one entry dated 24 February 2019 recorded an error with the wrong quantity of hydroxychloroquinine. The record stated that the team member involved had not correctly counted the quantity. The record stated that the team members were to ensure they marked all split boxes to help prevent the same error happening again. The pharmacy had a system to recorded dispensing incidents. No completed forms were available to look at. The pharmacy didn't record errors on the person's patient medication record (PMR). So, there was no prompt to remind the team of the error and prevent it happening again to the same person. The Superintendent Pharmacist and one of the dispensers completed an annual patient safety report. The 2018 report stated that as an online pharmacy the team had less work pressure and had plenty of time to take extra care when dispensing and doing clinical checks. The report stated that this led to fewer dispensing errors. The report stated that the pharmacy had clear and concise areas in the pharmacy specifically for dispensing, labelling and checking. And day to day operations ran smoothly. The report stated that the pharmacy separated medication with similar names or packaging. And the team tried to order specific brands of medicines with different packaging. The report stated that the shelves holding stock were untidy. So, the team had tidied the shelves. The report stated that the team members were to continue taking their time when dispensing and would be meticulous in their work. The report stated that all the team were aware of the concept of lookalike and sound alike (LASA) medicines and would continue being vigilant.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it

had information on how to raise a concern on its website. In April 2018 the pharmacy had sent surveys to people using the pharmacy asking them what they thought about its services. And they received informal feedback from people using the pharmacy. Following comments about missed deliveries the team reviewed delivery times. Many patients were elderly and didn't want an early morning delivery. So, the pharmacy had changed delivery times to start at 12 noon. The team had also asked people to provide a second contact number for the driver to ring when the person was not at home.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacist had spoken to the team about the requirements of the General Data Protection Regulations (GDPR). The pharmacist stated that the delivery driver was aware of information governance requirements and how to maintain people's confidentiality. The pharmacy's website contained its privacy policy. This detailed the confidential data kept and how the pharmacy complied with legal requirements. The team separated confidential waste and shredded it.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The dispensers had completed Dementia Friends training in 2017. The delivery driver had not received any training. But the driver had reported back to the team concerns they had about people they delivered to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to support the pharmacy's services. And they share information and learning particularly from errors when dispensing. The pharmacy team members do not have opportunities to complete more training. And they receive little feedback on their performance. So, they may miss the opportunity to reflect and identify training needs. And progress in their role or take on a new role to help the safe and effective delivery of services.

Inspector's evidence

The Superintendent Pharmacist covered the opening hours. Locum pharmacists provided occasional support. The pharmacy team consisted of two qualified dispensers and a delivery driver. One of the dispensers was the pharmacy business partner. At the time of the inspection only the Superintendent Pharmacist was on duty. The dispenser was due in at 11am as they were running late. The pharmacist didn't do any dispensing during the inspection. And explained they rarely had to dispense and check their own work.

The pharmacy didn't provide extra training for the team. The pharmacy held informal team meetings. The pharmacy provided informal feedback to the team members about their performance. Team members could suggest changes to processes or new ideas of working. One of the dispensers had used their experience from other pharmacies to suggest changes to the contents of the dispensing incident form.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The team used cordless telephones to make sure telephone conversations were held in private.

The premises were secure. The pharmacy had restricted access during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines appropriately. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. But the team does not always supply information leaflets with medication to help people take their medicines safely.

Inspector's evidence

The pharmacy was closed to the public. People could access the pharmacy website to get its telephone number to ring the team.

The pharmacy provided separate, marked areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The dispensers usually picked the stock for the prescription first. Then the pharmacist did a clinical check and produced the dispensing labels. The dispensers then attached the labels to the stock before the pharmacist performed the accuracy check. Most prescriptions were not needed on the day they arrived at the pharmacy. The team members did the picking and labelling on one day and then attached the labels and did the final check the following day. So, they had a mental break between the activities to help identify errors. On the rare occasion that the pharmacist dispensed and checked their own work they had a break between the two activities. This helped to identify errors. The pharmacist had updated the standard operating procedures (SOPs) to detail this.

The pharmacy provided multi-compartmental compliance packs to help 25 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions 10 days before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The team checked received prescriptions against the list on the patient medication record (PMR). And queried any changes with the GP team. The team recorded the descriptions of the products within the packs to help people identify their medicines. But it didn’t always supply the manufacturer’s patient information leaflets. The team stored completed packs on shelves labelled with the person’s name. And on sections marked with the day of the week. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And discussed the changes made by the hospital with the person’s GP. The team contacted the person to inform them of any changes requested by their GP. And highlighted any changes on the PMR. The team managed medicine changes by getting prescriptions to send new complete packs and getting the old ones back for destruction. Or, the team members provided enough of the new medication in a separate container to last until they sent the next supply of packs to the person.

The team members provided a repeat prescription ordering service. They used an electronic system as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team

regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The checks found one patient within the category who was switched to an alternate medicine.

The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team usually completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, the team contacted the person and asked if they wanted to wait for the full supply. The team kept the prescription in a separate basket to refer to when dispensing and checking the remaining quantity. And to ensure when the stock came in from the wholesaler it was used for the owing prescription. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy printed out the deliveries due each day. This also generated the best route for the driver to take.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 30 May 2019. The team highlighted medicines with a short expiry date. No out of date stock was found. The team members didn't always record the date of opening on liquids. This meant they may not identify products with a short shelf life once opened to check they were safe to supply. For example, an opened bottle of morphine oral solution with 90 days used once opened didn't have a date of opening recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. And it stored out of date and patient returned controlled drugs (CDs) separate from in date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. A box of Zomorph 10mg capsules was found that contained strips of capsules with different batch numbers and expiry dates. This would make it difficult to locate any affected stock when alerts came through. And increased the risk of the team not checking expiry dates.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). This Directive came out on 9 February 2019. The pharmacy had obtained information on FMD and the upgrades required for its computer software. The pharmacy obtained medication from several reputable sources including AAH and DE Specials. The pharmacist received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed the alert, actioned it and kept a record. The record was not available to see.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information.

The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door that allowed the viewing of stock without the door being open for a long time.
The pharmacy completed safety checks on the electrical equipment.

The pharmacy computers were password protected and access to peoples' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy held private information in areas which had restricted access.

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.