General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Karepack Ltd, 1st Floor, 11 Osram Road, East Lane business park, Wembley, HA9 7NG

Pharmacy reference: 9010568

Type of pharmacy: Internet / distance selling

Date of inspection: 21/08/2024

Pharmacy context

The pharmacy is in an industrial estate in northwest London. It has an NHS contract and dispenses prescriptions for people in nursing and care homes. The pharmacy is closed to the general public, so it does not see people face-to-face.

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	1.1	Good practice	The pharmacy's working practices are safe and effective. The pharmacy team members can show that risks are assessed and they devise new ways of working to make the pharmacy's services are safer.
		1.2	Good practice	The pharmacy team members carry out reviews and audits to identify where safety and quality of services can be improved.
		1.3	Good practice	The team members understand their roles and responsibilities within each part of the pharmacy team. And there are clear audit trails identifying who completed each part of a process.
2. Staff	Standards met	2.2	Good practice	The pharmacy supports and encourages team members to undertake ongoing learning and development relevant to their roles.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy maintains robust audit trails identifying team members who provide the services. And it manages the delivery service well so care homes receive their medicines safely on time.
		4.3	Good practice	The pharmacy manages its medicines stock well. It keeps records to show pharmacy stock is checked regularly, stored securely at the right temperature and safe to use. It has contingency plans to deal with power cuts which might affect storage temperatures.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It has systems in place for team members to continually learn from their mistakes and take action to prevent them happening again. The pharmacy actively monitors and risk assesses it services to improve their safety. It has suitable standard operating procedures in place which the team follow to manage the risks associated with providing services. It encourages people who use the pharmacy to give their feedback. The pharmacy keeps the records required by law showing it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they are trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems in place to review dispensing errors and near misses. The pharmacy team members recorded their mistakes and identified patterns in the types of error to learn from them and agree actions to reduce the chances of them happening again. The pharmacy regularly produced a patient safety review (PSR). A member of the team explained that medicines involved in incidents, or were similar in some way, were generally separated from each other in the dispensary. Lookalike and soundalike (LASA) medicines were highlighted to the pharmacy team members. And examples of these medicines were brands of amlodipine with very similar packaging or bendroflumethiazide and bumetanide which were stored near each other alphabetically and could be mixed up when picking medicines for prescriptions. Separating LASA medicines helped reduce picking errors. The superintendent pharmacist (SI) reported dispensing incidents to the NHS 'Learning from patient safety events' (LFPSE) service.

Members of the pharmacy team were each allocated a care home for which they were responsible 'end-to-end' dispensing their medicines. The pharmacy allocated a colour to the home. All the items for one home were placed in cages on wheels to help keep them together and avoid mix ups with orders for other homes. The wheeled cages made moving the orders around the dispensary easier. It supplied medicines in manufacturer's original packs, or each medicine in an individual blister pack to last 28 days and retained on a rack or in multi-compartment compliance packs each containing several medicines. The pharmacy did not repackage medicines if the patient information leaflet said they were to be stored in original packaging.

The SI explained that risk assessments (RAs) were generally triggered by an adverse event such as a dispensing incident or a discrepancy in the delivery to a home. The pharmacy risk-assessed the service and amended its processes to minimise the same thing happening again. An audit tested whether the RA was working and whether there were any items not delivered. So to help make sure the correct items were dispatched for delivery to a home, the team checked the controlled drugs (CDs), fridge items and number of boxes which were colour-coded meaning they went to the home allocated the same colour. This was helpful for the pharmacy planning its delivery schedule and avoiding delivery mistakes.

Care homes ordered their own prescriptions via the GP surgeries. When the pharmacy received them electronically, they checked them for any discrepancies and sent copies to the home. Prescriptions

were cross-checked against the care home list and missing items were chased up. The pharmacy had a goal or key performance indicator (KPI) to be able to dispense and supply 100% of the order with no missing items. The pharmacy had completed audits such as the anti-coagulant, asthma and antibiotics for the pharmacy quality scheme (PQS). And it was aware of new rules for supplying valproate to people and updated guidance which applied to supplying topiramate.

Members of the pharmacy team responsible for making up people's prescriptions used colour-coded baskets to separate each care home's medication. They worked to a matrix to make sure prescriptions were processed in a timely manner. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not packed until they were clinically and final checked by the pharmacist. Then the checked items were bagged and boxed in preparation for delivery. The dispensing audit trail was completed so the members of the team who were involved in dispensing and preparing the medicines for a care home could be identified at every step of the way. The pharmacist checked interactions between medicines prescribed for the same person and records of interventions were maintained on the patient medication record (PMR). Query prescriptions were kept separate until the query was resolved and they could then be delivered. Care homes had a specific person to receive and book in the medicines delivery which the pharmacy had carefully checked and booked out.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed and updated by the superintendent pharmacist (SI). The SOPs included responsible pharmacist (RP) procedures, complaints and delivery and were available on an electronic portal. The SI could monitor progress with training in the SOPs. Members of the pharmacy team had read the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy maintained training records for all team members. After each monthly prescription cycle, the pharmacy contacted care homes and asked what went well and how could they improve next month. And people could leave feedback and access the complaints procedure on the website.

The pharmacy displayed a notice that told people who the RP was and it kept a record to show which pharmacist was the RP and when. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The PMR was encrypted, backed up regularly and the team members had access appropriate to their role in the pharmacy. Consent of people in the care home was recorded electronically and the PMR was annotated. Any service information such as hospital discharge medicines service (DMS) or new medicines service (NMS) was recorded on PharmOutcomes. The pharmacy rarely dispensed private prescriptions and the dispensary manager described how specials or unlicenced medicines supplies were recorded. The pharmacy maintained a controlled drug (CD) register. And the stock levels recorded in the CD register were checked weekly. A random check of the actual stock of a CD matched the amount recorded in the CD register.

The pharmacy was registered with the Information Commissioner's Office. The pharmacy team had trained in information governance, and the pharmacy computer was password protected. The pharmacy displayed a policy on its website that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy tried to reduce paper as much as possible by maintaining electronic records. Team members made sure people's personal information was disposed of securely. They stored their NHS Smartcards safely when they were not in use. And the data security and protection toolkit had been completed.

The pharmacy had a safeguarding SOP. And the pharmacists had completed a level 3 safeguarding training course. Members of the pharmacy team including the delivery drivers knew what to do or who

they would make aware if they had concerns about the safety of a vulnerable person. The team were signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who are qualified or training and have the appropriate skills and qualifications for their roles. Members of the team work effectively together and manage the workload in a supportive environment. The pharmacy team can provide feedback which is actioned. And they know how to raise concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team comprised two full-time pharmacists, four full-time and one part-time trainee or qualified dispensing assistants, one part-time team member to unpack and check the order and two part-time delivery drivers who had completed accredited training and were Disclosure and Barring Service (DBS) checked.

Members of the pharmacy team were enrolled on or had completed accredited training relevant to their roles. They worked well together, following the pharmacy’s procedures so prescriptions were processed safely. They completed the audit trail identifying who was involved at each stage of preparing each prescription. And there was a delivery audit trail showing safe delivery to the respective care home. The pharmacy conducted training audits to monitor training effectiveness and needs.

The pharmacy supported team members with training via elearning resources to progress their roles and by allocating protected learning time if needed. The team had undertaken training in safeguarding, manual handling, confidentiality, general data protection regulation (GDPR) and mental health. The pharmacy maintained a record of qualifications and planned training for the team members.

The pharmacy held regular team meetings and minutes were recorded. Team members could provide feedback in meetings or via the suggestion box on making changes to how they work such as changing the delivery day and designing a colour-coded spreadsheet of planned deliveries. They had appraisals at set intervals to monitor progress and devise a performance development plan in line with their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The stock room and dispensary were temperature controlled. The pharmacy was spacious and fitted out with shelving units to accommodate the pharmacy’s medicines stock and workbenches where team members prepared prescriptions. The pharmacy did not have face-to-face contact with people who used the pharmacy’s services. The pharmacy was cleaned by the team who maintained a record of when the premises were cleaned. The pharmacy website contained information about the pharmacy, including its services, medication information, feedback and how to contact them. It displayed the pharmacy address and SI details.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is an internet pharmacy so it does not see people who use its services face to face. The pharmacy team members are good at managing their workstreams and providing pharmacy services safely and effectively. The pharmacy team maintains thorough audit trails identifying each team member involved in providing each part of the service. The pharmacy obtains its medicines from reputable sources and stores them securely at the right temperature so that they are fit for purpose and safe for people to use. People taking higher-risk medicines are provided with the information they need to use their medicines properly. The pharmacy takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy's opening hours were on its website along with other information about its services. The pharmacy's services were promoted by word of mouth. Members of the pharmacy team were helpful and signposted people to another provider if a service was not available at the pharmacy. The pharmacy was generally contacted directly by the hospital when people were discharged from hospital. The pharmacy provided a delivery service as people did not attend its premises in person. It conducted audits of the service to monitor its quality and identify where it could be improved. The delivery matrix was displayed on a white board in the dispensary. The pharmacy allocated a colour to the care home so everything to be delivered to the same home was endorsed with the same colour and placed together for dispatch. The pharmacy also sent an electronic copy of the drop sheet with each order. The pharmacy delivered medicines securely at the correct temperature to a few care homes at a time. Care homes had a specific person to receive and book in the medicines delivery which the pharmacy had carefully checked and booked out.

The pharmacy team members were each allocated a care home for which they would prepare the current order for medicines. They could explain their workstreams as the same team member was responsible for preparing all the medicines from receipt of the prescriptions to dispatching the medicines for the same home. Depending on the needs of the home and the people who lived there, the pharmacy supplied medicines in manufacturer's original packs, or in an individual blister packs on racks to last 28 days or in multi-compartment compliance packs each containing several medicines. The pharmacy did not repackage medicines if the patient information leaflet said they were to be stored in original packaging. High risk medicines were supplied separately and not included in multi-compartment compliance packs. For medicines requiring therapeutic monitoring, the care home was notified of blood test results for medicines such as warfarin or methotrexate and appropriate counselling was provided.

Where required it produced electronic medication administration record (MAR) charts. It checked new batches of prescriptions for changes since the previous batch and recorded interventions. Communication with care homes was via email. Team members provided people with a description to help identify individual medicines. Descriptions included batch number and expiry dates in case of an alert or recall. And patient information leaflets (PILs) were supplied either with medicines or they could be found on the website.

The pharmacy provided training in care homes such as medicines administration, completing a MAR chart, administration and over-use of 'when required medicines' such as salbutamol or paracetamol. And a review of how the home ordered some medicines and explaining how to calculate what they needed and reduce waste. The pharmacy had service level agreements (SLAs) with the homes setting out arrangements to delivery on a specific day, supply acute medicines, CDs, fridge items and new medicines. The pharmacy had a business continuity plan and in the event of a power cut, the team members were notified straight away and could switch to electrical generators.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. The pharmacy kept its medicines and medical devices in their original manufacturer's packaging. And marked liquid medicines with a date of opening. The pharmacy team checked the expiry dates of medicines regularly and recorded when this was done. Short-dated medicines were highlighted and recorded. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. Waste medicines were accepted back from care homes in line with the SLA. Medicines recalls and alerts were printed, stock was checked and a record was kept. The pharmacy team could track individual batches and contact the relevant homes supplied with a particular batch. The pharmacy's SOPs covered dealing with recalls, alerts and yellow card reporting.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy team had access to online up-to-date reference sources. The pharmacy had several fridges to store pharmaceutical stock and prescriptions awaiting dispatch requiring refrigeration. And the maximum and minimum temperatures of each refrigerator was monitored and recorded. The medical refrigerators were re-calibrated annually. The pharmacy team kept records of when the pharmacy was cleaned and there was fire safety equipment.
The pharmacy collected confidential wastepaper for secure disposal. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they entered their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they were not working.

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.