General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Drugs 4 Delivery.Com, Unit 4, Acorn Business Park, Moss Road, Grimsby, Lincolnshire, DN32 0LT

Pharmacy reference: 9010768

Type of pharmacy: Internet / distance selling

Date of inspection: 08/06/2023

Pharmacy context

The pharmacy is in a business park close to Grimsby. Its main activities are dispensing NHS prescriptions. People access the pharmacy services through its website and they can contact the team by telephone and email. They do not visit the pharmacy premises and they receive their medicines by delivery to their home. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take them properly. It dispenses private prescriptions from prescribers that provide an alcohol detoxification service for people.

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 adequately identifies and manages the risks associated with its services. It has written procedures and access to prescribing policies that the pharmacy team uses to help provide its services safely. It generally completes the records it needs to by law. The pharmacy encourages people to provide feedback about its services, which team members suitably respond to. Team members help protect vulnerable people and keep people's confidential information secure. Pharmacy team members respond appropriately when errors occur and they take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The Superintendent Pharmacist (SI) was transferring the SOPs to an electronic format and a few SOPs had been transferred including the management of controlled drugs (CDs). However, these SOPs didn't have a date of preparation or a review date. Team member's knowledge and understanding of the SOPs was tested by answering a few questions related to the SOP. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy dispensed a few prescriptions from prescribers that provided a private alcohol detoxification service for people. The pharmacist owners had evaluated the risks of providing this service and undertaken governance checks on the clinic providing the service. Separate SOPs and specific guidance were in place to support the dispensing of the prescriptions for the alcohol detoxification medication issued by the private prescribers. And the pharmacists were provided with the prescribing policy for prescribing these medicines. The pharmacy's procedures included a guide for team members to refer to when checking the registration status of the private prescribers on the General Medical Council's register. The SI had used the documents provided by the clinic and from meetings held with the team at the clinic when assessing the risks of providing the service. However, a full risk assessment linked to the pharmacy's role in providing the service had not been documented. The pharmacists had a good understanding of the medicines prescribed and would contact the prescribers with queries about the prescriptions. These interventions were not captured on the pharmacy's patient medication record (PMR). The pharmacy had not undertaken any formal audits of the service to ensure the prescribers were following their prescribing policies.

The pharmacists and accuracy checking dispensers (ACDAs) when checking prescriptions and spotting an error asked the team member involved to identify and correct the error. This helped the team member reflect on why the error occurred. The pharmacy kept records of these errors, known as near misses. However, these were completed by the pharmacist or ACDA rather than the team member involved. So, team members didn't have the opportunity to capture their thoughts about the error and how they'd prevent it from happening again. A sample of completed records showed the sections to capture learning points and actions to prevent the error from happening again were not completed. The two pharmacist owners regularly reviewed the near miss records to identify patterns which were shared with the team. Recent reviews highlighted quantity errors were the most frequent errors and were often linked to partially used packs of medicines. The team discussed this and agreed to clearly mark the original packaging when some of the medication was removed. The pharmacy had a separate

procedure for managing errors that were identified after the person received their medicines, known as dispensing incidents. Following a recent dispensing incident all team members were made aware of the error. And after a recent error had agreed the learning to prevent similar errors by completing a second accuracy check of the dispensed medicine at the point of supply to the person.

The pharmacy's website provided a form for people to raise a concern and a separate questionnaire for people to provide comments on its services. A feedback form was also sent with people's medicines and the delivery drivers reported any queries or concerns raised by people back to the team. For example, when the person wanted to discuss their medication, this was passed onto the pharmacist to contact the person. One of the dispensers was responsible for initially dealing with queries raised by people via telephone and email before raising them with the pharmacists when required.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal and good practice requirements. The pharmacy used electronic platforms for the RP record and the CD registers which were password protected. The RP record captured when the RP had been absent from the pharmacy, but it didn't always record the reason for the absence. The pharmacy website didn't display details on the confidential data kept and how it complied with legal requirements. Team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

Team members had received safeguarding training relevant to their role and understood their responsibilities to protect children and vulnerable adults. The delivery drivers reported concerns back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team with a wide range of skills and experience. Team members work well together and support each other in their day-to-day work. They complete some training so they can suitably develop their skills and knowledge. They identify areas of their own practice they wish to develop. And the pharmacy supports them to achieve their aims.

Inspector's evidence

Two pharmacist owners, one who was the SI, covered most of the pharmacy's opening hours with locum pharmacist support when required. A large pharmacy team consisting of 15 team members supported the delivery of the pharmacy's services. Team members included a trainee pharmacy technician, three full-time dispensers, two who were ACDAs, two trainee ACDAs and two pharmacy apprentices. Seven drivers provided the pharmacy's delivery service which covered a large geographical area. At the time of the inspection one the pharmacist owners, the ACDAs, two pharmacy apprentices and three of the delivery drivers were on duty. The team members on duty worked well together and supported each other to manage the workload.

There were some opportunities for team members to complete additional training and it was centred around that required for the NHS Pharmacy Quality Scheme, such as safeguarding. One of the ACDAs and a dispenser had recently been trained as vaccinators to support the pharmacists with the seasonal flu vaccination service and the COVID-19 vaccination service.

The team held regular meetings with all team members and in smaller groups for team members in a specific role. The pharmacist owner used a recent meeting to remind all team member to ensure telephone calls were answered as he'd noticed calls were often left unanswered. Team members were advised to not break off from key tasks such as dispensing to answer the telephone. And to ask a colleague who was not involved in such tasks to answer the telephone. Team members shared up-to-date information using an instant messenger group.

Formal and informal feedback on their performance was provided to team members who were also given opportunities to develop their skills. One of the delivery drivers had expressed interest in the role of supervisor for the team of drivers. They had discussed this with the pharmacist owners who agreed to create the position of supervisor. And supported the driver as they developed the skills for the role.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy has appropriate premises for its services. They are suitably clean, hygienic, and secure. And the pharmacy provides good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were clean, tidy and hygienic. There were separate sinks in place for the preparation of medicines and hand washing. And hand sanitising gel was available for team members to use. Room temperatures were appropriately maintained, and the rooms were well lit. There was plenty of space for dispensing activity to take place and sufficient storage space for medicines and medicinal stock.

The pharmacy had two large, well-equipped, and sound-proof consultation rooms which were used for services such as the seasonal flu vaccinations and COVID-19 vaccination. A separate room was used as a waiting area for people attending for these services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to help people meet their healthcare needs. Team members adequately manage the pharmacy services to help make sure people receive medicines when they need them. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The public could not directly enter the pharmacy to access services except when attending for vaccination service. Its website provided information on the pharmacy's opening hours and the contact details of the pharmacy. The pharmacy supported an out-of-hours service to help people access palliative care medicines, which was frequently used by healthcare professionals in the area. The pharmacists contacted people prescribed new medicines as part of the NHS New Medicine Service (NMS). And used a room away from the main dispensary to telephone the person to maintain their privacy. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. A regular review of people prescribed valproate was undertaken to identify anyone who may meet the PPP criteria.

The pharmacy dispensed a few prescriptions for medicines used for alcohol detoxification issued by private prescribers at a local clinic. The prescribers at the local clinic undertook consultations in person and by telephone. People's identities were checked as part of the service. Details from the consultation including test results, such as liver function tests, were provided to the pharmacy. The clinic's procedures and prescribing policies were shared with the pharmacy, so pharmacists could check that prescribed treatments were within the clinic's procedures and policies. For example, the prescriber was contacted if the pharmacist identified the person was taking opioid medication which was contraindicated when taking alcohol detoxification medication. The pharmacy's PMR captured the details of the consultation and counselling advice given to the person by the pharmacist.

The pharmacy dispensed medicines in multi-compartment compliance packs to help many people take their medicines. One of the full-time dispensers managed this service with support from other team members. The preparation of the packs was divided across the month. And prescriptions were generally ordered several days before supply to allow time for issues such as missing items. However, to help manage timescales associated with dispensing the packs, the team occasionally assembled the packs before the pharmacy received the prescriptions. This was done against the record the pharmacy held that listed the person's current medication and dose times. Once the prescription was received a check of the packs and the backing sheets supplied with the packs was made against the prescriptions. This was done by a dispenser and a pharmacist before the pack was supplied. An SOP for dispensing and checking the packs was in place and covered this process. The team sometimes recorded the descriptions of the products within the packs. But they didn't supply the manufacturer's patient information leaflets. This meant people could identify the medicines in the packs but didn't receive information about their medicines with the packs.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent

them becoming mixed up. There were checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. The ACDA completed the accuracy check of the prescriptions after the pharmacist had marked the prescription to indicate a clinical check had been completed. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. Completed prescriptions awaiting delivery were stored in a dedicated area so they were readily available for the driver. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable suppliers. Team members mostly followed the SOPs to ensure the medicines were safe to supply. This included regular checks of the expiry dates on stock and keeping a record of this activity. But a sample of medicines with short expiry dates were not marked to prompt team members to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines were still safe to use. Team members checked fridge temperatures and kept a record of the readings. And a sample of these records showed they were within the correct range. The pharmacist owners received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. And forwarded them to the team to action. A check was made to ensure the team had received the alert and had taken the appropriate action. But a record was not kept demonstrating this had happened.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And fridges for holding medicines requiring storage at this temperature. The pharmacy computers were password protected and access to people's records 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.