General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Atropa Pharmacy Online, Unit 299 National Avenue, The Ideal Business Park, Hull, East Riding of Yorkshire, HU5 4JB

Pharmacy reference: 9010778

Type of pharmacy: Closed

Date of inspection: 25/05/2021

Pharmacy context

This pharmacy is a distant selling pharmacy and access to the premises is generally closed to the public. People can access the pharmacy website and contact the pharmacy by telephone. The pharmacy's main activities are dispensing NHS prescriptions and supplying medicines in multi-compartment compliance packs to help people take their medication. It also provides a few private services such as travel vaccinations. The pharmacy was inspected during the COVID-19 pandemic.

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 generally identifies and manages the risks associated with its services including the risks from COVID-19. When people report that the pharmacy's services are not to the required standard the pharmacy listens and makes suitable changes to the way it works. The pharmacy team members demonstrate a clear understanding of their role in safeguarding the safety and wellbeing of children and vulnerable adults. And they respond promptly and suitably when concerns arise. Pharmacy team members respond suitably when mistakes happen. They discuss what has happened and they mostly take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had completed COVID-19 risk assessments for all team members to identify their personal risk of catching the virus. The pharmacy had plenty of space to enable team members to maintain social distancing requirements. The pharmacy team had access to Personal Protective Equipment (PPE) and conducted regular COVID-19 tests. A few team members wore PPE during the inspection. The pharmacy was closed to the public except for people accessing the private services. The services were provided in downstairs rooms that were away from the dispensary that was based upstairs. People were asked to wear a face covering and use the hand sanitiser.

The pharmacy had a range of standard operating procedures (SOPs) that the Superintendent Pharmacist (SI) was in the process of reviewing. The SOPs provided the team with information to perform tasks supporting the delivery of services. The SOPs were kept electronically and sent to each team member to read. Not all of the team members had signed the SOP's signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had procedures for handling errors that occurred during the dispensing process and for dispensing errors that reached the person prescribed the medication. The pharmacist when performing the final check of the prescription and spotting an error asked the team member involved to identify the error and correct it. A record of the error, known as a near miss, was kept electronically. However, not all the team members had been trained on how to record their own errors. This meant the pharmacy didn’t have a complete record of all the near miss errors to help the team identify patterns and make changes to prevent errors from reoccurring. Errors that reached the person, known as dispensing incidents, were also recorded electronically. All team members, whether directly involved with the error or not, were informed of the error to ensure they were aware of it and could learn from it. The team identified that keeping low levels of medicine stock helped to keep the shelves tidy and reduced the risk of picking errors.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And its website provided people with information on how to contact the team to provide feedback or raise a complaint. The pharmacy had responded to concerns raised by people about delays to the supply of their medication and problems people encountered when attempting to telephone the pharmacy. The pharmacy had made significant changes to the procedure for preparing multi compartment compliance packs. And in February 2021 it had installed an additional six telephone lines. The pharmacy team recently sent forms to people using the compliance packs service asking for

comments on how the service was previously provided. And for feedback on how the service was being provided since the changes were introduced. One of the trainee dispensers had previously worked in a customer service role and was leading this project. The team members provided the relatives of people who had experienced delays with supplies of their medication with their work mobile number so the relative could speak directly to a team member. The team members found this helped them respond promptly to concerns and to take any necessary action to ensure the person received their medication. People using the pharmacy services and their family members were also provided with the pharmacy's email address.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records met legal requirements. However, the RP notice was not being displayed at the start of the inspection. The RP on duty printed off their notice during the inspection to display. The pharmacy team was aware of the requirements of the General Data Protection Regulations (GDPR). The pharmacy website referred to a privacy policy but this was not clearly displayed. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team responded appropriately when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support its services. And it provides team members with protected time to complete their training. The team members support each other in their day-to-day work. They discuss and share ideas and they identify improvements to the delivery of pharmacy services.

Inspector's evidence

The SI and a regular locum pharmacist covered most of the opening hours. The pharmacy team consisted of a full-time dispenser who was the pharmacy manager and owner, a full-time qualified dispenser, three full-time trainee dispensers, an administrative assistant and two delivery drivers. At the time of the inspection all the team members were on duty. Team members were given protected time for their training and trainees were encouraged to ask the experienced team members for help with any queries they had. The pharmacy manager spent time with each team member to discuss any concerns they had about working during the pandemic. These conversations resulted in some team members changing their working hours.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. The team had a WhatsApp group to share information and ideas. The pharmacy manager organised regular events to thank the team members for their help and support. The pharmacy manager encouraged team members to raise concerns about the pharmacy procedures and systems. And he felt empowered and supported to support the safe delivery of pharmacy services. One of the team had developed a spreadsheet to capture the completion of the different stages of processing the compliance packs. The same team member had used their experience of working in a customer service department to suggest the pharmacy asked people who received compliance packs for feedback on the service. This was agreed and the team member was leading on this project.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic with separate sinks in place for the preparation of medicines and hand washing. The team used cleaning products and alcohol wipes to clean the compliance packs that were returned to the pharmacy for re-use. 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 premises were secure and the pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had good sized and soundproof consultation rooms to provide the private services. These were cleaned after each appointment.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are well-managed so people receive appropriate care. The pharmacy keeps detailed records to help monitor the services it provides. This enables the team to deal with queries effectively. And it makes sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores and manages its medicines and appliances correctly.

Inspector's evidence

The pharmacy was closed to the public which meant people could not directly enter the pharmacy except when attending for services such as the private travel vaccination service. The pharmacy website provided people with contact details of the pharmacy and the opening hours. The website also provided details of the services offered and a series of frequently asked questions (FAQs) to help people with their queries.

The pharmacy provided multi-compartment compliance packs in the form of Pivotell automatic pill dispensers to help around 200 people take their medicines. The pharmacy was the main provider of the Pivotell devices in Hull. The pharmacy had made significant changes to the processing of the Pivotell devices in response to several concerns raised about delays with the supply of the devices to some people. The changes included supplying the devices on the same day to the person and using coloured baskets labelled with the person's name to hold the prescription, medicine stock and Pivotell device. The coloured baskets were specific to the day of supply. This ensured all team members knew what stage the processing of each device was at. The pharmacy had trained all the dispensers on how to prepare the devices to prevent any disruption to the service if a team member was off work. The pharmacy had updated the process for supplying external medicines such as inhalers to people receiving the Pivotell devices. The team made a record on each prescription accompanying the devices to show when the external medication had been ordered and supplied to the person. The team noticed after introducing this process a decrease in phone calls from people asking about their external medication. The team used a spreadsheet to record the completion of the different stages of processing the devices. The team did not write the descriptions of the products within the devices and didn't always supply the manufacturer's patient information leaflets.

The pharmacy had experienced delays with the receipt of some prescriptions for the Pivotell devices. The team had worked with the teams from the medical centres in Hull to ensure prescriptions arrived in time for dispensing. A few prescriptions arrived a day or two before the medication was due out to the person. The team was aware of these prescriptions and prepared for the arrival of the prescriptions by getting the stock ready and storing the baskets on dedicated shelves marked 'awaiting prescription'.

The team members had worked together to support the changes to the processing of the Pivotell devices. And they were at the stage where dispensing was two days before the supply was due out to the person. The dispensers often visited people at home to help them understand how to use the Pivotell devices. The team found this approach helpful especially for people who often contacted the pharmacy with concerns their device was not working or their medicine had been incorrectly added. Each person had two devices; one was in use whilst the other was at the pharmacy for dispensing. The team checked the returned Pivotell devices to ensure there were no technical issues and to identify medication that hadn't been taken. This would trigger contact with the person's GP and care provider

where appropriate to raise awareness that the person was not taking their medication.

The pharmacy provided multi-compartment compliance packs to 24 care homes. The team provided the care home team with medicine administration charts to record when the person had received the medicines. The care home team used the charts to inform the pharmacy team of medicines that had been ordered or had been stopped. And medicines that the person still had but did not need to be ordered. The pharmacy team kept the charts for a few weeks after the supply was made to refer to in case any queries arose. The pharmacy usually sent the packs and other medicines to the care home a few days before the next cycle started. This gave the care home team time to check the supply and chase up missing medicines.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. 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 found that the team completed the boxes. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 the delivery driver did not ask people to sign for receipt of their medication. Each delivery driver had a GPS tracker to capture the date and time of a successful delivery to a person's home. The GPS information was linked to the person's electronic record kept at the pharmacy. This enabled the team to check what medication had been supplied and when. The pharmacy contacted people to confirm delivery or to advise of delays with supplies due to the medication being out of stock. This enabled the person to inform the pharmacy that they were happy for the supply to be put on hold and arrange another delivery time. When the person needed their other medication before the out-of-stock medicine was due to arrive at the pharmacy the team made the supply. And sent the remaining medication in a separate container clearly labelled with the dose and time of day to be taken.

The pharmacy obtained medication from several reputable sources. One of the trainee dispensers regularly contacted medication suppliers for up-to-date information on the availability of stock. And shared this information with the rest of the team. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out of date stock was found. The team checked and recorded fridge temperatures each day. A sample of these records 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably 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 had equipment available for the services provided. The equipment included a range of CE equipment to accurately measure liquid medication. The pharmacy had a large fridge to store medicines kept at these temperatures. The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. The pharmacy held private information in the dispensary 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.