General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy-Xpress, Unit 32, Fountain Business Park, Fountain Lane Oldbury, Birmingham, West Midlands, B69 3BH

Pharmacy reference: 9010861

Type of pharmacy: Internet / distance selling

Date of inspection: 28/11/2022

Pharmacy context

This pharmacy has an NHS distance selling contract and specialises in providing pharmacy services to care homes. The pharmacy is located in a purpose designed unit on an industrial estate and people cannot visit this pharmacy in person. Services and information can be accessed through the pharmacy's website, www.pharmacy-xpress.co.uk. The pharmacy offers a range of options so care homes can choose how their medicines are supplied and some prescriptions are assembled using a dispensing robot.

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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely. They record their mistakes so that they can learn from them. And they make changes to stop the same sort of mistakes from happening again. The pharmacy is responsive to feedback and uses this to make improvements.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. The pharmacy had an electronic system for many of their records, and information and SOPs were held electronically within this system. This allowed the superintendent (SI), responsible pharmacists (RPs), the Group Regulatory Pharmacist (GRP) and other members of the team to easily view what training was outstanding and address any training needs. Roles and responsibilities were highlighted within the SOPs. Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection.

The pharmacy was part of a larger group of pharmacies owned by different legal entities that shared a number of the same company directors. Whilst each of the companies had a different SI, they shared a GRP who visited all of the pharmacies in the group to provide assurances to the owner on governance and other regulatory matters. The GRP visited the pharmacy at the start of each month to undertake a professional standards audit. This audit monitored the daily, weekly and monthly checks that the pharmacy team were expected to carry out and provided the SI and the pharmacy owners with assurance that the pharmacy was operating as they expected it to. The GRP also reviewed any dispensing errors that had been reported and ensured that a comprehensive review had taken place and that improvements had been identified and implemented. The GRP led a monthly meeting with the pharmacy team in which learning from other pharmacies within the group were shared, and updates from NHS, Local Pharmaceutical Committees (LPCs) and GPhC were discussed along with any local issues. The accuracy checking technician (ACT) made notes during these meetings and these were uploaded to the electronic system so that they could be seen by anyone that was not present, or for future reference.

Near miss records were held on the electronic system and a ‘dashboard’ summarised the number of near misses recorded. There were Quick Response (QR) codes displayed in the dispensary so that the dispensers could scan the QR code using their mobile phone and enter the details of any near misses. The ACT explained that she would make someone aware of a near miss and ask them to record it themselves so that they could reflect on the mistake, but she also kept a note to remind herself to check that it had been added to the electronic system by the end of the day. The ACT reviewed the near misses in preparation for the monthly meeting and any key learnings were presented. The pharmacy team gave some examples of different types of mistakes and gave some examples of how processes had been adapted to avoid the same mistake happening again. Dispensing errors were recorded, reviewed and reported to the GRP using the electronic system. The GRP lead reviewed the error and contacted the SI if anything else was required. Dispensing errors were also reported to a national

database called NHS learn from patient safety events (LFPSE) service.

Some risk assessments had been undertaken for the NHS Pharmacy Quality Scheme (PQS). The GRP had designed the daily, weekly, and monthly checklist and the monthly audit to address some of the known risks for pharmacies. The GRP had not been in their role for many months, and she was planning to undertake some additional focused risk assessments for the pharmacy once she had embedded the monthly review process. Ideas for these risk assessments were discussed with the team, and the pharmacy were developing a formal risk assessment and policy for determining which medicines could be added to the robot and the maximum amount of time they could be outside of their original packaging.

The complaints procedure was explained in the SOPs and in the patient leaflet on the pharmacy website. The pharmacy contact details were available on the website. The SI explained that feedback was dealt with as it occurred and gave examples of how feedback had been used to make improvements. The pharmacy employed a care home liaison manager who was the main point of contact for care home managers or representatives if they had any issues. She spent most of her time visiting care homes to provide training on the systems that the pharmacy supplied care homes with, and she acted as an intermediary to resolve any issues. The pharmacy team responded to feedback from care homes and explained that they were very conscious that the care homes had their own regulatory requirements. They understood that delivering monthly medication on the agreed date was important to the homes as they planned their staffing around performing their own checks on the medication prior to the starting dates. The pharmacy had previously operated a COVID vaccination service from an associated site in Dudley. There were several hundred positive reviews for the service on Google Reviews.

The pharmacy had up to date professional insurance arrangements in place. The RP notice showed the correct details and was clearly displayed. The RP log was compliant with requirements. Controlled drug records were electronic, and a CD balance check was completed regularly and recorded. Private prescriptions were recorded in a record book and records were in order. Specials records were maintained with an audit trail from source to supply. Home delivery records for controlled drugs were signed by the recipient as proof of delivery and a copy retained by the pharmacy and by the care home. There was an electronic system for tracking the delivery vans, and another system for recording deliveries.

The privacy policy was available on the pharmacy's website. Members of the pharmacy team had completed training on information governance. Confidential waste was stored separately and securely destroyed. The pharmacy was registered with the ICO. The pharmacy had a safeguarding policy for children and vulnerable adults. The pharmacy professionals had completed level 2 training on safeguarding and the rest of the team had undertaken an NHS elearning module.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so they always have enough cover to provide the services. The team members work well together in a supportive environment and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the superintendent (SI), a regular locum pharmacist, an accuracy checking technician (ACT), a care home liaison manager (dispenser), a supervisor (dispenser), four dispensers, a driver co-ordinator and five delivery drivers. The SI was a company director and could discuss with the other directors if any additional support staff were required. Requests for annual leave were made in advance using a smartphone app and approved by the supervisor. There was a maximum number of people that could be off at any one time to ensure the pharmacy service was not interrupted and rotas were amended if needed.

The GRP set monthly training modules for the pharmacy team and these were generally based on the requirements of the NHS Pharmacy Quality Scheme, plus refresher training for topics such as safeguarding and data security. The team had access to various online training platforms. Compliance with the monthly training was checked as part of the audit. The pharmacy team had one-to-ones with either the superintendent or supervisor every month to discuss their performance and to discuss any work or personal issues they may have.

The team members worked well together during the inspection and were observed helping each other. They discussed the workload and any issues on an ongoing basis, and they held a weekly meeting after completing the work due, before starting the next cycle of prescriptions. There was also a more formal monthly meeting. The team explained they felt that they were kept well informed. Part of the role of the supervisor was to ensure that each person was carrying out the tasks for the workstation that they were assigned and gave them coaching when necessary.

The pharmacy staff said that they could discuss any ideas, concerns or suggestions with the SI, owner or RP, and felt that they were responsive to feedback. Team members were aware of the whistleblowing policy, and this was displayed in the pharmacy for easy reference. No formal targets for professional services were set. The main target was delivering medication to care homes on the date agreed with the home.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. The pharmacy's website provides clear information to people about the pharmacy's services.

Inspector's evidence

The pharmacy used a website to promote the services offered; www.pharmacy-xpress.co.uk. The website contained details of the pharmacy such as the name of the superintendent (SI), the premises address, services offered and contact details for the pharmacy. The pharmacy had been for applied and been given permission to display the GPhC voluntary logo on their website, but it was not displayed.

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the SI and local contractors were available to sort out any issues. There was a business continuity plan displayed which listed the names and contact details for maintenance contractors. There was a stock room, and another room was used for returned medicines so that they were stored away from the main dispensary. A board room style office area was used for meetings.

The dispensary provided ample space for the services provided and an efficient workflow was in place. Administration, dispensing and checking activities took place in separate areas of the pharmacy. There was an additional area specifically for the robot and for storing medication for the robot to dispense.

The pharmacy was clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff on a rota basis. The sinks in the dispensary and staff areas had hot and cold running water, and hand towels and hand soap were available. The pharmacy had a large portable heater and a portable air conditioning unit. Lighting was adequate for the pharmacy services offered. Prepared medicines were held securely within the pharmacy premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services and supplies medicines safely. The pharmacy gets its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use.

Inspector's evidence

The pharmacy had an NHS distance selling contract, so members of the public did not access the pharmacy premises to collect prescriptions. It focused primarily on providing medicines for care homes and a team of delivery drivers took these to the homes rather than using a courier service. The pharmacy had started to offer the NHS New Medicine Service (NMS) to patients when the rules changed during the pandemic and had continued to do this as they felt it was beneficial to patients even though they were living in care homes. The pharmacy could provide prescriptions to people in any part of the country if it was to receive a prescription, however, requests for this were extremely rare as most of the care homes were within the local area.

There were three options available for the care homes for their monthly medication and these were discussed with the care homes when they joined the pharmacy. The options included: original pack dispensing and medication administration record (MAR) charts, original pack dispensing and electronic MAR charts (eMAR) and compliance pack dispensing and eMAR. The pharmacy tried to encourage homes in the first instance to dispense from original packs with a MAR or eMAR chart, and compliance packs were offered as an alternative solution if the care home required them. The pharmacy had invested in an eMAR system that was intended to support care homes with their medication administration by having photographs of the patient to help agency or new staff identify them, and by having warnings built into the system.

The pharmacy supplied regular prescription medication (monthlies) and any additional medication that may be prescribed during the month (acutes). Monthlies were sent to the care homes on a specific date so that the staff at the home could book the medication in and acutes were sent as soon as possible after the prescription was received by the pharmacy. The monthly workload was carefully planned and the team's progress was tracked using a white board. Members of the team were assigned different tasks based on the progress of the workload, and these were co-ordinated by the supervisor.

Monthly prescriptions were received electronically by the pharmacy and labelled by a dispenser. The dispenser identified if there were any missing items or changes from the previous monthly supply and made a list of these. This list was emailed to the care home once the labelling had been completed and the care home then used this list to action the points and update the pharmacy team. One of the pharmacists then clinically checked the prescriptions and recorded this check by initialling the 'clinically checked by' box on the prescription. Prescriptions were then assembled using the robot for compliance packs, or original packs and then accuracy checked by the ACT or a pharmacist.

Acute prescriptions were labelled and dispensed as soon as the prescription was received and placed

into a coloured basket to identify it as an acute, and to identify which driver route it would go out with. If the pharmacy did not have sufficient stock for an acute prescription, the team would send some medication and inform the home by email that there was some outstanding. There was always a dispenser assigned to 'admin' and they would download and prioritise prescriptions, take telephone calls, inform the care homes of medication that was unavailable, and complete other daily tasks. There was a call record and a task list on the computer so that the team could chase any outstanding tasks without having to rely on anyone remembering. The pharmacy team contacted the care homes if they had any questions about a person's medication or if they had any specific counselling to provide. This included counselling and ongoing monitoring of high risk medicines such as valproate.

The stock for the robot was de-blistered and placed into canisters. Each canister contained the same batch number and expiry date so that there were no mixed batches. The SI performed a second check before the canisters were authorised to be loaded into the robot. The computer system that accompanied the robot photographed the medication and printed them onto the labels, and these were attached to the packs so that people could differentiate between the different medicines in there.

Stock was removed from its original packaging and placed into labelled, food grade containers containing desiccants in preparation for it to be loaded into a canister. The computer system for the robot contained usage information, but this was not used to define how much medication to de-blister at any one time. This meant that the length of time between medication being de-blistered and administered was unknown. The SI agreed to review this after the inspection and to work with the GRP to risk assess and create a policy to tighten controls on stock management for the robot.

Each of the delivery vans had a tracker and this allowed the pharmacy team to inform the care homes how long the driver would take to get to them if they phoned the pharmacy to ask. It also gave the pharmacy team assurance that a driver had been to the correct location if a care home said that medication was not delivered. In addition, the driver used a smartphone device to record deliveries and take signatures as proof of delivery.

Date checking took place monthly and no out of date medication was seen during the inspection. There was a date checking matrix used to record date checking. The medicines in the robot were used up quickly, and the robot tracked expiry dates and had the ability to alert the team if there were any short dated batches in the canisters. Medicines were stored in an organised manner on the dispensary shelves. All medicines were stored in their original packaging, until they were de-blistered for the robot. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Medicines were obtained from a range of licenced wholesalers and the pharmacy was alerted to drug recalls via emails from the MHRA through the computer system and the action taken was recorded. Patient returned medicines were stored separately from stock medicines in a room specifically for this purpose.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. A CD cabinet access log was used to record when the CD cabinets had been opened and by whom. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The equipment is serviced regularly and there is a contingency plan in place in case the equipment fails.

Inspector's evidence

The pharmacy had access to a range of reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Counting triangles were used and there was a separate, marked triangle used for cytotoxic medicines. Computer Screens were not visible to the public as they were not able to access the pharmacy.

A dispensing robot was used to assemble some medicines and the team members that used the robot had received training on how to use it. The robot was serviced regularly, and the owners had subscribed to a maintenance package which meant that if the robot malfunctioned a specialist would be available promptly. The team could resort to manual dispensing if technical problems with the robot could not be resolved.

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.