General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prescription Care Services, 1C Packington Hayes, Tamworth Road, Lichfield, Staffordshire, WS14 9PN

Pharmacy reference: 9011071

Type of pharmacy: Community

Date of inspection: 18/05/2023

Pharmacy context

This is a distance selling pharmacy which occupies the first floor of a purpose-built industrial unit in a rural area in South Staffordshire, near to the towns of Lichfield and Tamworth. The pharmacy mainly dispenses and delivers NHS prescriptions directly to people across the United Kingdom and to a small number of care home residents. It is not generally open to members of the public, but the pharmacy provides some private services such as travel vaccinations on an appointment basis only.

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 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, and they complete tasks in the right way. They discuss their mistakes so that they can learn from them. The pharmacy team keeps people's information safe and understand their role in supporting vulnerable people.

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 core SOP folder had been filtered so that the SOPs relevant to the main activities were easily accessible to the pharmacy team and other SOPs were stored in another folder. The SOPs had been revised by the Superintendent (SI). Some minor updates to the SOPs were needed to reflect some changes to UK legislation. Signature sheets were used to record training and staff had signed training logs relevant to their job roles. Roles and responsibilities of staff were highlighted within the SOPs. Pharmacy team members were knowledgeable about their roles and discussed these during the inspection.

Many of the pharmacy's processes and records were managed electronically, which meant that records were easily accessible. And the computer system included automatic alerts to remind the pharmacy team to do certain tasks. Near miss records were held on this 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 the near miss. The pharmacy team gave some examples of different types of mistakes and demonstrated some examples of how processes had been adapted to try and avoid the same mistake happening again. Medicines with similar names (look alike, sound alike) were highlighted on the dispensary shelves as a visual prompt when dispensing, and posters were displayed which contained information about learning from commonly make mistakes in pharmacies. The near miss log was reviewed by the SI on a regular basis and discussed with the team. The computer system created an annual patient safety review for the NHS Pharmacy Quality Scheme (PQS) report. Dispensing errors were recorded and reviewed on the electronic system.

People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and would involve the SI if they could not reach a solution. The pharmacy communicated with the care homes that it supplied medicines to by email as it provided an audit trail for prescription queries, and it was a convenient way for both the care home and the pharmacy to keep in touch. A secure messaging service application (app) was used to let people know when their prescription was due to be delivered. The team explained that this had helped reduce the number of failed deliveries as it was easy for the person to let the pharmacy team know that they would not be home.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was displayed in the dispensary and the RP log met requirements. Controlled drug (CD) registers were in order and a random balance check matched the balance recorded in the register. Delivery

records were maintained. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and destroyed securely by a specialist company. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The privacy policy was on the pharmacy's website. The SI had completed safeguarding training. The pharmacy team understood what safeguarding meant. A dispensing assistant gave examples of types of concerns that she may come across in her role and described what action she would take.

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 the pharmacy has enough staff cover to provide the services. The team works well together in a supportive environment, and team members can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the superintendent (RP at the time of inspection), an accuracy checking dispensing assistant, two dispensing assistants, two trainee dispensing assistants, and a home delivery driver. The accuracy checking dispensing assistant was working towards a level three qualification and was due to finish the course within the next few months. They planned to become a pharmacy technician soon after qualifying. Holidays were discussed with other team members to ensure no-one else had already booked the same week and cover was provided by other staff members as required. A part time trainee dispensing assistant worked extra hours when required. Pharmacy team members completed ongoing training and training needs were identified to align with new services, seasonal events and the NHS Pharmacy Quality Scheme (PQS). The team members had regular appraisals.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with other tasks when required. Two of the more experienced team members were the leads for care home dispensing and compliance pack dispensing. However, the team were trained to carry out all tasks within the dispensary so that there was a contingency for absence. Other tasks were delegated to different members of the team so that the workload was well managed. The pharmacy staff said that they could raise any concerns or suggestions with the SI and felt that they were responsive to feedback. Team members said that they would speak to other members of the team, or contact GPhC if they ever felt unable to raise an issue internally. No targets were set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for the provision of healthcare services.

Inspector's evidence

The pharmacy used a website; www.prescriptioncareservices.co.uk to promote the services offered. The website contained details of the pharmacy such as the name of the SI, the premises address, the services offered, some health advice information and useful links, the complaints procedure and contact details for the pharmacy. There was a separate website that promoted the private services offered by the pharmacy.

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the SI or the landlord dependent on what the problem was. The premises were clean and tidy with no slip or trip hazards evident. Cleaning was undertaken by pharmacy staff. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap available. The pharmacy was heated using central heating and portable heaters. Lighting was adequate for the pharmacy services offered. Prepared medicines were held securely within the pharmacy premises.

The dispensary and offices were an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the dispensary. A separate office was used for organising completed prescriptions for the driver or courier to take. There was a large room used as a consultation room for private services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services and supplies medicines safely. It gets its medicines from licensed suppliers and stores them securely and at the right 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. The pharmacy services could be accessed via telephone and e-mail. Whilst the pharmacy services were available to people across the UK, there was very little demand from outside of the local area, so medicines were usually delivered directly to people by the pharmacy driver. Royal Mail was used to deliver prescriptions to people outside of the usual delivery areas. The pharmacy had recently started working with a third-party website company that facilitated repeat NHS prescription ordering from surgeries. The pharmacy had access to the system so that they could see what had been ordered and contact the patient through the website if there were any problems with the prescription.

Private patient group directions (PGDs) were available for travel vaccinations and male pattern baldness. The pharmacy team reported that travel vaccinations were very popular. The SI was accredited to offer these treatments after completing online training and being named on the PGD. The certificates were displayed in the consultation room and additional information was available online. The SI had access to a helpline if he had any questions about the PGD and he was observed querying an allergy during the inspection. The SI had plans to expand the private services available.

Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. There was a messaging service built into the patient medication record (PMR) and people were alerted if there was a delay with their prescription due to stock shortages, and it could be used to send other messages. These included messages such as changes to opening hours due to bank holidays and asking the person to contact the pharmacy with their INR levels if they were prescribed warfarin. The pharmacy team were aware of the MHRA and GPhC alerts about valproate and had counselling information available. Prescriptions that were suitable for the accuracy checking dispensing assistant (ACDA) to accuracy check were initialled by the pharmacist to demonstrate that he had carried out a clinical check. And the ACDA confirmed that she would not carry out an accuracy check unless the prescription had been initialled.

Multi-compartment compliance packs were supplied to people in the community. Prescriptions were requested from the surgeries around a week in advance to allow for any missing items to be queried with the surgery ahead of the intended date of collection or delivery. A sample of dispensed compliance pack prescriptions were labelled with descriptions of medication and patient information leaflets were sent with each supply. There was a process in place for managing mid-cycle change requests. The SI had carried out a suitability assessment for most compliance pack patient's and had provided alternative options, such as medication administration record (MAR) charts or large print labels if he had not deemed compliance packs as the most suitable option for the person.

Date checking took place regularly and no out of date medication was found during the inspection. The pharmacy team maintained date checking records and medication was pro-actively removed prior to its expiry date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically and marked when they were actioned.

The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridge was 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. And the team uses it in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date 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 available. Computer screens were not visible to the public as members of the public were excluded from the dispensary. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.