General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: IPharmac, Room1, rear side, 12 Hart Road, Fallowfield, Manchester, Greater Manchester, M14 7LE

Pharmacy reference: 9011096

Type of pharmacy: Internet / distance selling

Date of inspection: 27/11/2019

Pharmacy context

This pharmacy situated in a shopping parade of a suburban residential area. It is a distance-selling pharmacy, so people do not visit the pharmacy in person. Its main service is supplying NHS prescription medicines via its home delivery service. It also sells non-prescription medicines to UK residents via its website www.Ipharmac.co.uk and its webpage listed as Ipharma-direct on the e-commerce retailer website eBay.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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 generally manages risks well. It provides the pharmacy team with written instructions to help make sure it provides safe services. The team records and reviews its mistakes so that it can learn from them. It keeps people's information secure. And the team understands its role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy had written procedures that had been reviewed in May 2019 and were scheduled to be reviewed again in two years' time. These procedures covered safe dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CD). Staff provided a record that confirmed they had read these procedures, but the record itself did not make clear which procedures each individual had read and understood. Staff also said that the delivery drivers had read the delivery procedures, but they had not yet signed the record.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each prescription medication supplied and assisted with investigating and managing mistakes. The pharmacy team discussed and recorded mistakes it identified when dispensing medicines and addressed each of them separately. However, staff did not always discuss or record why they thought each of them happened, and they did not review these records. So, they could miss additional opportunities to learn and mitigate risks in the dispensing process.

Staff referred any complaints to the managing director, who was also a pharmacist. However, there was no information displayed on the pharmacy's website about how to make a complaint, so people might not know how they could do this. The pharmacy had not collected people's feedback through a patient satisfaction survey.

The pharmacy had professional indemnity insurance for the services it provided. The RP, who was the resident pharmacist, displayed their RP notice. The pharmacy maintained the records required by law for the RP and CD transactions. The pharmacy could usually obtain a prescription the same day as people made their request, so it had not had to record any medication supplied urgently without a prescription. It also maintained records of medicines manufactured under a specials licence that it had obtained and supplied. The pharmacy rarely received private prescriptions. However, records for medications supplied in 2017 and 2018 against two private prescriptions had not been made until October 2019, so these records were not kept up to date and this could make it more difficult for the team to explain what has happened in the event of a query.

The pharmacy's privacy notice was accessible via its website. Staff had each signed an agreement to keep people's information confidential and had a basic understanding of protecting people's data. The pharmacy had detailed policies on protecting people's data, but staff had not read them. Staff securely stored and destroyed written confidential material and used passwords to access people's electronic data. Some team members had their own NHS smart cards. But others used one of their colleague's cards to access people's NHS information, which affected the integrity of the associated audit trail, and could make it difficult to confirm who had viewed it. Staff asked security questions before proceeding to discuss confidential information with people who telephoned the pharmacy. The pharmacy had obtained people's written consent to access their prescription via the NHS electronic prescription

service (EPS). Staff obtained people's verbal consent when they agreed to the pharmacy ordering their prescription. But the pharmacy did not obtain their written authority to do this, which could help in the event of a query. The pharmacy had not completed the equivalent of a data protection audit, so there could be areas of risk that remained unidentified.

The RP and senior dispenser had level two safeguarding accreditation. The other team members had completed training on the basic principles of safeguarding and the Dementia Friends material. However, the pharmacy did not have its own safeguarding procedures or access to the local safeguarding board's contact details or procedures. The team reported safeguarding concerns to the GP when people exhibited signs of confusion which, in some cases, led to the pharmacy dispensing their medicines in multi-compartment compliance packs. The pharmacy had records of the care and delivery arrangements for people who had known safeguarding issues, and it also kept the next of kin details for them, so they could be contacted easily if needed. The team consulted these people's carer and GP about whether to supply medication every seven or twenty-eight days, but it did not keep corresponding records of these assessments.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe services. The team members work well together and usually have the right qualifications for their role. However, delays in training for new team members and the lack of a structured ongoing training programme, could mean that gaps in team members' skills and knowledge are not identified or supported.

Inspector's evidence

The staff present included the RP, the senior dispenser and an undergraduate pharmacy student. The other staff, who were not present, included a trainee dispenser and two delivery drivers. The pharmacy had enough staff to comfortably manage its workload. The team usually had repeat prescription medicines, including those dispensed in compliance packs, ready in good time for when people needed them. People did not personally visit the pharmacy, so the team avoided any sustained periods of increased workload pressure. The pharmacy did not have any official targets for volume of services it provided, such as the number of prescriptions it dispensed or people who nominated it to obtain their electronic prescription.

The staff present worked well both independently and collectively, and they used their initiative to get on with their assigned roles and required minimal supervision. They effectively oversaw the various dispensing services and had the skills necessary to provide them. The experienced dispenser confidently managed the day-to-day operational matters in relation to these services.

The trainee, who had been employed six months and was studying a biological science degree had only started their training around two months ago, and they were completing a medicines counter assistant (MCA) course, instead of studying towards a dispensing qualification. However, the managing director, who was the previous resident pharmacist, had subsequently enrolled the trainee on the correct course.

The managing director regularly held informal discussions with each team member about their performance, but there was no formal performance review process. And qualified staff did not participate in any structured or planned programme of ongoing training.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s service, and it provides a professional environment for healthcare services. The pharmacy’s website provides accurate information about its services.

Inspector's evidence

The pharmacy was situated at the rear of a retail unit, the front of which the pharmacy owner used as a separate retail business. Its office, storage and medicine packing areas were suitably maintained and it was professional in appearance: The open-plan dispensary area provided enough space for the volume and nature of the pharmacy's service. A consultation room was unnecessary because people did not visit the premises. The level of cleanliness was appropriate for the service provided. And staff could secure the premises to prevent unauthorised access.

The pharmacy was registered with the Medicines and Healthcare products Regulatory Agency (MHRA) to supply prescription and non-prescription medicines via its website and General Sales List (GSL) and pharmacy (P) only medicines via the online e-commerce site eBay.

Several randomly selected pages from the pharmacy’s website each displayed the MHRA distance-selling logo. The pharmacy’s owner details, address, contact telephone number and email address were suitably displayed on the pharmacy’s website. However, its previous address was also referenced in another section of the website, which could cause confusion. The superintendent’s identity was not displayed anywhere on its website, so people may have difficulties finding this information if needed. People would be referred to a third-party pharmacy if they requested to purchase non-prescription medicines via the pharmacy’s own website. This other pharmacy was registered with the MHRA, and its parent company was identified on the pharmacy's website. However, the other pharmacy was not identified prior to people being redirected to the other pharmacy's website. So, it could be difficult for people to fully establish who was involved in the service. But the website was subsequently updated and these issues were addressed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are suitably effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers and manages them effectively to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy operated from 9am to 5pm Monday to Friday. Most people telephoned the pharmacy to order their NHS repeat prescription, and they also had the option to do this via the pharmacy's website. The pharmacy completed most requests on the day it received them.

The pharmacy's website had a health advice section that took its content from the NHS website nhs.uk. Randomly selected sections, including for infections and pain, included information on the condition, when and how to self-treat and when to consult the GP.

The risk of the pharmacy persistently selling non-prescription medicines inappropriately was low. Several randomly selected treatment categories on the pharmacy's own website, including for pain relief and sleep aids did not list any P medicines. The managing director said that the pharmacy had not sold any of non-prescription medicines via the other pharmacy's website. It had only sold a minimal number of these medicines via eBay, and not received any repeated requests for the same non-prescription medication from the same individual. The director also said that opiates were not listed on the pharmacy's own or its eBay online platform.

The pharmacy limited people to using a payment method on eBay that only allowed them to register one account. And they could only link one bank account to the registered account. This made it more difficult for an individual to set up more than one payment account and, therefore, repeatedly purchase the same medication covertly via eBay.

The team routinely checked each person's eBay and payment account purchase history with the pharmacy. It also checked this via the pharmacy's own database compiled from people's purchase history. These systems helped to identify anyone repeatedly attempting to purchase the same or similar medication.

The managing director explained that the pharmacy sent people an online questionnaire every time they requested a medicine via eBay. These questions were based on a standard questioning model used to make sure the pharmacy ascertained the person who would take the medication, their symptoms and how long they had them, any action the person had taken so far and any other medication they were taking. The RP reviewed all the responses before deciding on an appropriate course of action.

The pharmacy would redirect all non-prescription medicine requests place on its website to the third-party pharmacy's website. However, the pharmacy had not checked how effectively the third-party would screen these requests that were referred to it. So, the quality of this service was unclear.

The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including anti-coagulants and methotrexate, but did not have any for valproate, insulin, lithium or fentanyl patches. The RP had checked all the people prescribed valproate, which confirmed the

pharmacy did not have anyone in the at-risk group. However, staff could not locate the MHRA approved valproate advice booklets and cards to give people in the at-risk group, but knew how to obtain them.

The RP regularly checked that people on anti-coagulants and methotrexate had a blood test when ordering their next prescription, but they did not keep corresponding records, so they couldn't fully demonstrate this. They also checked if these people were experiencing any side-effects or interactions. The RP had also advised people on how to safely use and dispose of their fentanyl patches.

The team prompted people to confirm the repeat medications they required, which helped it limit medication wastage and made sure people received their medication on time. The team also kept records of the medications requests, so could effectively resolve queries if needed.

The team scheduled when to order prescriptions for people who used compliance packs, so that it could supply their medication in good time. It kept a record of these people's current medication that also stated the time of day they were to take them, which helped it effectively query differences between the record and prescriptions and reduced the risk of it overlooking medication changes. The pharmacy also kept records of verbal communications about queries and changes to medication for people using compliance packs. However, these were not in a structured format, which could risk important information being overlooked. The team labelled compliance packs with a description of each medicine inside them, which helped people to identify them.

The pharmacy obtained its medicines from a range of licensed pharmaceutical wholesalers and stored them in an organised manner. However, it did not have a system for complying with the Falsified Medicines Directive (FMD).

The pharmacy suitably secured its CDs and could properly quarantine those that were date expired and patient returned. Records indicated that the pharmacy monitored the medication refrigerator storage temperatures every day and they were consistently within a safe range. Staff said that they checked stock expiry dates every two weeks and had supporting records from the last few weeks, but they could not locate any similar documentation prior to this period. Several randomly selected medicines from stock had a long shelf life. Two eye or nose drop products were due to expire at the end of December 2019, but staff explained that they disposed of stock one month before its expiry.

The team took appropriate action when it received alerts for medicines suspected of not being fit for purpose, but its supporting records did not always make clear who handled the alert or when they did this. The pharmacy disposed of obsolete medicines in waste bins kept away from medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable.

The pharmacists initialled each CD register supply entry, which assisted in identify who was responsible for each of these supplies, including delivered CDs. Records indicated that the pharmacy securely delivered prescription medicines to people.

The team packed non-prescription medication to be delivered in robust and discrete packaging. The pharmacy handed all its parcelled medicines to external couriers, who immediately scanned each parcel into its system. This allowed the pharmacy and intended medication recipient confirm when the medication had been delivered to the destination address. The managing director said that parcels were only removed from the pharmacy when the RP was present, as required under the RP regulations.

The pharmacy usually honoured its promise to supply non-prescription medicines within seven to ten days after the request. And people had not reported any delay receiving their medication. A few people had reported damaged medication containers, usually creams, which the pharmacy refunded or

replaced. However, the pharmacy had not raised the matter with the courier concerned, so similar issues might reoccur .

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. It suitably stores and maintains the equipment, and it has the facilities to secure people's information.

Inspector's evidence

The team kept the dispensary sink clean and it had access to hot and cold running water and an antibacterial hand sanitiser. A range of clean measures were also available, so staff had the facilities to make sure it did not contaminate the medicines they handled and could accurately measure and give people their prescribed volume of medicine. Team members had access to the BNF and cBNF online to check pharmaceutical information if needed.

The team had facilities that protected peoples' confidentiality. The team viewed people's electronic information on screens not visible to the public and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public view.

The pharmacy also had facilities to communicate securely online with people. The product purchase checkout page on its website stated that connection to its website and App software were secure and encrypted both in information transmission and storage on its servers. It also stated that people's information was encrypted and transmitted via secure third-party services when it sent emails, push and SMS notifications.

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.