

# Registered pharmacy inspection report

**Pharmacy Name:** One Stop Pharmacy, Unit G, Key Industrial Park,  
Fernside Road, Willenhall, West Midlands, WV13 3YA

**Pharmacy reference:** 9011139

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 10/03/2020

## Pharmacy context

This is a specialist home healthcare pharmacy which offers services to private hospitals, care homes, NHS Trusts and to people through its website; [www.onestop-pharmacy.co.uk](http://www.onestop-pharmacy.co.uk). The pharmacy specialises in supplying treatments for mental health conditions. People cannot visit this pharmacy in person, and it is located in a large unit on a business park. It has an NHS distance selling contract and it dispenses repeat prescription and it supplies some medicines in multi-compartment compliance packs.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	2.2	Good practice	Pharmacy staff have regular performance and development reviews and complete additional training relevant to their job role.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy effectively identifies and manages the risks associated with its services to make sure people receive appropriate care. It is responsive to feedback and it uses this to make improvements. 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.

### 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. SOPs had been prepared by the pharmacy manager and had been approved by the superintendent and clinical director. Signature sheets were used to record staff training and staff read and signed SOPs relevant to their job role. Roles and responsibilities of pharmacy staff were highlighted within the SOPs.

The pharmacy offered a range of different pharmaceutical services including; NHS dispensing to individual patients and to care homes (original pack dispensing and multi-compartment compliance packs), dispensing services to NHS organisations (a home healthcare model), dispensing for patients in private hospitals, supply of stock medicines for private hospitals via their MHRA WDL, and provision of medicines information (including ward round visits at private hospitals and information about specific medicines to the NHS organisations that use the home healthcare service).

A near miss log was used and the dispenser involved was responsible for reporting and correcting their own error to ensure they learnt from the mistake. Each near miss was discussed at the time to see if there were any reasons for the near miss, and it was used as a learning opportunity. The pharmacists reviewed the near miss log for patterns and trends every month and discussed near misses with the team to see if there were any further learning opportunities. A root cause analysis was completed when there was a dispensing error and the staff members were informed so that they could reflect on the error. A risk assessment was carried out before a new service started. A risk assessment for a clozapine supply service had helped the team to identify several improvement actions that they had since put into place.

The pharmacists had either completed or were undertaking additional qualifications in psychiatric therapeutics which helped when designing risk assessments or day-to-day accuracy checking and clinical checking of prescriptions. Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant answered hypothetical questions related to responsible pharmacist absence correctly.

A complaints procedure was explained in the SOPs. People could contact the pharmacy by telephone, email, fax (although this is being phased out) and by using a contact form on the website. The pharmacy provided specialist commissioned services to some NHS organisations who had requested an online prescribing system. The superintendent was working with NHS Digital to design a new system with this

facility. The pharmacy gathered customer feedback by completing an annual customer survey as part of their NHS contract. The superintendent (SI) explained that feedback was dealt with as it occurred and gave examples of how feedback had been used to make improvements. The clinical director was also the client relationship manager and they contacted care homes and private hospitals regularly for feedback. Some private hospitals had requested that the pharmacists make additional checks to support their CQC inspections when they did their ward rounds, so this had been added to the service level agreements (SLA).

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. A CD balance check was completed regularly, and a random balance check matched the balance recorded in the register. A patient returned CD destruction register was used. Private prescriptions were recorded electronically, and records were in order. Specials records were maintained with an audit trail from source to supply.

The pharmacy had various information governance policies. Members of the pharmacy team had read and signed the policies and had signed confidentiality agreements. Confidential waste was stored separately and destroyed securely by a specialist company. The pharmacists could access NHS Summary Care Records.

The pharmacy had a safeguarding policy. The pharmacists had completed the level 2 training on safeguarding and the rest of the team had completed level 1 training. The pharmacists also completed the 'in-house' safeguarding training for the different hospitals that they visited and had Disclosure and Barring Service (DBS) checks. The home delivery driver had been given training on safeguarding and this included some specific information about how to manage interactions with people with mental health conditions, as he delivered directly to some people's homes as part of the one of the SLA's.

## 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. They complete additional training to make sure that they have the knowledge and skills for the specialist services that they offer, so they are well qualified and competent.

### Inspector's evidence

The pharmacy team comprised of the pharmacy manager, pharmacist, pre-registration trainee, four dispensing assistants, an apprentice and a delivery driver. The team was supported by the superintendent (SI) and the clinical director. Recruitment checks were carried out for each member of staff and this included providing evidence of accredited training. The company was family-owned, and the SI and clinical director had direct control of staffing budgets. The SI had made the decision to over-staff the pharmacy so that they were ready to take on new business and staff could be trained to do different tasks.

The clinical director had completed a postgraduate certificate in psychiatric therapeutics and a clinical diploma. She provided on-the-job training for pharmacists during their induction period in how to undertake ward rounds at the private hospitals. Pharmacists continued to shadow more experienced pharmacists on ward rounds to increase their knowledge and experience. The pharmacists were also enrolled in the course following their induction period and had the option to continue to the full clinical diploma upon completion of the certificate. The pharmacy had a contract with NHS organisations to supply specific medicines. The medicines were supplied directly from the manufacturer's and as part of the contract the pharmacists had medicines information training provided by the manufacturer, so that they could answer questions from NHS staff about the medicine, such as, titration regimen after a missed dose or suitable needle depths.

The pre-registration trainee was undertaking a split placement and had already completed a six-month placement in a traditional community pharmacy. She did not have a lead-role in the pharmacy which allowed her to gain experience in every role and she also shadowed pharmacists on ward rounds. She was allocated four hours of training time every week and was on-track with performance reviews.

There was a 'lead dispenser' for each part of the pharmacy business and the pharmacy team were trained to be able to carry out each task so they could cover each other's annual leave or unplanned absence. The team had huddles during the day and helped their colleagues when required. Holidays were booked in advance with the pharmacy manager to ensure there was enough cover. The team did overtime or swapped shifts to cover holidays, and a part time member of staff was available to work additional days when required.

Each member of staff was allocated a training budget which could be used to order training which was relevant to their individual learning and development needs. For example, some of the training budget had been used to purchase credits from CPPE so that dispensing assistants could access modules. Some of the training was linked to the commissioned services that were provided. And the pharmacy

manager used some of his training budget to attend workshops linked to his role as the responsible person for the MHRA wholesale dealer's licence. Staff members had a performance review every six-months and a competency assessment. The competency assessment contained a section for staff to identify their own learning and development needs for discussion during the performance review.

The team worked well together during the inspection and were observed helping each other throughout. The team had regular huddles in the dispensary and also had a more formal meeting every six-months in the board-room for refresher training. A pharmacist had recently designed and delivered a training session which included topics such as the Falsified Medicines Directive (FMD) and private prescription requirements.

The RP was observed making herself available to discuss queries with people on the telephone. Targets were in place and role-specific targets were written into the employee's individual contract for the annual year. Targets were reviewed quarterly and were linked to pharmacy tasks being completed, rather than services. The pharmacy staff said that they could discuss any ideas, concerns or suggestions with the pharmacists or SI and they would contact the GPhC if they had any concerns that were not addressed by the SI or pharmacists.

## 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 to promote the services offered; [www.onestop-pharmacy.co.uk](http://www.onestop-pharmacy.co.uk). The website contained details of the pharmacy such as, the GPhC voluntary logo, the premises address, services offered and contact details for the pharmacy. Some of the details that were required, such as, the name of the superintendent (SI), complaints procedure and details of how to check the registration status of the pharmacy and SI were missing from the website. The pharmacy did not sell medicines through the website or offer an online prescribing service. A Covid-19 statement was clearly displayed on the front page of the website and listed some of the measures in place to maintain service.

The premises were smart in appearance and well maintained. There was a business continuity plan which listed details of who should be contacted if needed. Any maintenance issues were reported to the landlord. The pharmacy had opened in April 2019 and had relocated from another premises which had since closed. The pharmacy had been renovated to the requirements of the team, there was ample workbench and storage space and space to install additional workbenches if the business grew. Various offices, boardroom and staff lounge area were upstairs in the unit.

The dispensary was large, and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate worktops and there was ample space for prescription storage. A separate area of the premises was used for MHRA wholesale activity. Risk assessments for health and safety and fire safety were in the SOP folder to ensure that the staff were aware of their contents. There was also a company recycling and environmental policies.

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 fan heaters and portable heaters and monitored ambient temperature. 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. It gets its medicines from licensed suppliers and stores them securely and at the right temperature, so they are safe to use. The pharmacy team effectively supports other healthcare professionals in providing specialist services, as well as traditional dispensing services.

### Inspector's evidence

Dispensing processes were well organised. 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.

Prescriptions were delivered using an employed driver or by various other courier services dependent on the service required and the location of the delivery. Prescription deliveries were signed for by the recipient and the pharmacy could track orders online and see evidence of delivery if required. This also allowed the recipient to be given an estimated delivery time if required.

A prescription collection service was in operation. The pharmacy had audit trails in place for the prescription collection service and prescriptions collected were routinely checked against requests and discrepancies followed up. A dispenser explained the process for checking the received prescription against the request.

Monthly and acute prescriptions were provided to some local care homes. Audit trails were in place for each of the homes and the process for ordering, dispensing and delivering was explained. Members of staff were assigned to different tasks and they had been trained so they could undertake each task to provide contingency cover. A dispensing assistant contact the care home if a medicine for an acute prescription was not in stock so that the care home could decide whether to wait until the following day or obtain the medication from another pharmacy.

Multi-compartment compliance packs were dispensed for people in the community. Prescriptions were ordered in advance to allow for any missing items or prescription changes to be queried with the surgery ahead of the intended date of supply. A sample of dispensed compliance packs were seen to have been labelled with descriptions of medication, and an audit trail for who had been involved in the dispensing and checking process.

Private hospitals ward rounds were carried out by the pharmacists and stock was supplied under the pharmacy's MHRA WDL. The frequency of the ward rounds was agreed with the hospital and was part of the contract. There was a written policy explaining what the pharmacists checked during the ward rounds and this was available in the SOP folder. The wards that the pharmacists visited were mental health wards and the additional training that the pharmacists completed supported the clinical checks. The stock supplied to the hospitals was supplied against requisitions and the MHRA had inspected the pharmacy since it had opened.



A home homecare service was provided for some NHS organisations. The medicines for one organisation were supplied directly to the patient and with the other one, the medication was administered by a nurse, so the prescriptions were supplied to a central address. A dispensing assistant was the lead for the home healthcare service and explained the prescription journey for the larger of the two services. There was an SLA in place and there was a named contact at the organisation. Each patient was contact before their delivery to arrange a convenient date. There were processes in place in case the patient did not answer the door to the driver.

The pharmacy team had a special interest in psychiatric therapeutics and a large percentage of the medicines supplied were to patients in specialist mental health settings. The pharmacist was aware of the additional checks and counselling for certain groups of people that were prescribed valproate and had undertaken a valproate audit prior to the pharmacy move, but other members of staff were not aware. Sodium valproate was dispensed into plain boxes and compliance packs, but the special warning sticker was not attached. Dispensing labels were attached over the warning label on some of the original packs. The pharmacist agreed to review the current process, to brief the team and to order any of the counselling materials that they could not locate.

Medicines were stored in an organised manner on the dispensary shelves. All medicines were stored in their original packaging. Medicines were obtained from a range of licensed wholesalers, manufacturers and a specials manufacturer. Split liquid medicines with limited stability once opened, were marked with a date of opening. No out of date medicines were seen during the inspection, but date checking records were not available for inspection as the internet was not working at the time and it was held on Google Drive. The pharmacy was compliant with the Falsified Medicines Directive (FMD) and verified stock when it arrived and decommissioned during the accuracy check process. Patient returned medicines were stored separately from stock medicines in designated bins. The pharmacy received MHRA drug alerts by email from gov.uk and printed, annotated and filed the recalls once actioned.

The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Secure procedures for storing the CD keys were in place. There was a medical fridge used to hold stock medicines and assembled medicines. The medicines in the fridge were stored in an organised manner. 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 services safely. The pharmacy team uses the equipment in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had 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 and there was a separate, marked triangle used for cytotoxic medicines. Screens were not visible to the public as members of the public were excluded from the dispensary.

### 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.