General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Push Pharmacy, Unit 3, 242 Romford Road, London, E7 9HZ

Pharmacy reference: 9011144

Type of pharmacy: Internet / distance selling

Date of inspection: 07/10/2024

Pharmacy context

The pharmacy is a distance selling pharmacy (pushpharmacy.co.uk) and is located inside an industrial unit in East London. The pharmacy mainly dispenses NHS prescriptions as well as a small number of private prescriptions. It also provides multi-compartment compliance packs to people who live in their own homes and need help managing their medicines. The pharmacy is closed to the public and medicines are delivered to people using a delivery driver.

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 adequately manages the risks associated with its services. And it keeps the records it needs to by law, so it can show that supplies are made safely and legally. Team members respond appropriately when mistakes happen during the dispensing process. People who use the pharmacy can provide feedback. But some team members are not provided with training about safeguarding which may mean they are not able to deal with concerns appropriately.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). Individual training records were signed by current team members to confirm that they had read and understood the SOPs. Team members were observed following the SOPs when dispensing prescriptions.

There was ample space to dispense and check prescriptions. Work benches were kept clear of clutter. The pharmacist generated the labels and clinically checked the prescription before the dispenser labelled the medicine packs. The pharmacist carried out an additional check when handing the dispensed medicine to the driver. Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were seen to be documented routinely on monthly logs. The pharmacist reviewed the near miss record and completed a patient safety review at the end of the month. The reviews included information on action to be taken by the team to reduce the risk of errors. The team described changes they had implemented in response to near misses, for example, placing caution stickers on the shelves to highlight medicines that looked alike or sounded alike. Every person accessing the pharmacy's services was assigned a number and this allowed for an additional check. Team members said this helped reduce the risk of delivering the incorrect medicine as some people had similar-sounding names. A procedure was in place for dealing with dispensing mistakes which had reached a person, known as dispensing errors. The pharmacist described the action the pharmacy team would take, and this included rectifying the mistake and documenting it.

The correct responsible pharmacist (RP) sign was displayed. Team members understood their roles and responsibilities. The RP record was kept electronically, and samples checked were in order. The pharmacy had current indemnity insurance cover. The private prescription register was held electronically, and samples checked were in order. The pharmacy did not provide emergency supplies. Controlled drug (CD) registers were maintained in accordance with requirements and the running balances were checked at regular intervals. A random stock check of a CD agreed with the recorded balance.

People were able to provide feedback online, over the telephone, or verbally to the delivery driver. The complaints procedure was available on the pharmacy's website. The pharmacist said that the pharmacy tried to order repeat prescriptions well in advance to help reduce delays in people receiving their medicines.

All team members had read the General Data Protection Regulation workbook, the pharmacy's information security incident procedure, and the data security policy. They knew the importance of protecting confidentiality, and described ways they did this, for example, the delivery driver checked a person's assigned number when handing medicines to reduce the risk of sharing confidential

information. Computers were password protected and individual smartcards were used to access the pharmacy's electronic records. Confidential waste was shredded at the pharmacy. All pharmacists had completed training about protecting vulnerable people, but the dispenser had not completed any training and could not describe signs of abuse or neglect. The pharmacist said that they would ensure that all team members would be provided with the relevant training. There had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills.

Inspector's evidence

During the inspection, the pharmacy was covered by a regular pharmacist and a dispenser. Pharmacy shifts were also covered by the owners who were all pharmacists. Locum pharmacists were booked occasionally. Team members managed their workload well throughout the inspection.

Team members had access to online training modules and were provided with time to complete ongoing training. Certificates were retained at the pharmacy. The dispenser had completed several modules including infection prevention, health and safety, and working as a healthcare support worker. They had also recently completed a master's degree on healthcare leadership. The pharmacist said that they attended webinars and read material on the Community Pharmacist website to help keep their knowledge and skills up to date. They had also completed a clinical diploma in community pharmacy.

Team meetings were held regularly with the owners and team members could share information via a telephone messaging App. Team members said that they were comfortable to raise concerns or give feedback to the owners and said that the owners were always open to suggestions. A whistleblowing policy was available. Targets were not set for the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And the pharmacy’s website provides the relevant information for people.

Inspector's evidence

The pharmacy was in an industrial unit and was accessed via a set of stairs. It comprised of a staff room with kitchenette, a large dispensary, and two additional rooms. One room was used as an office and the other as a storage room. The dispensary was fitted with shelves and workbenches. Stock was stored in an organised manner on the shelves. The sink area was clean and tidy.

The pharmacy main door was fitted with a bell and was kept locked at all times. There was a fire exit door in the dispensary which was kept clear. The pharmacy had adequate lighting, and the ambient temperature was suitable for storing medicines. The pharmacy was clean and was secured from unauthorised access. The cleaning was shared by the team.

People were able to sign up for the NHS prescription delivery service via the pharmacy’s website. The website contained the relevant information including the pharmacy’s address, registration number, and details of the superintendent pharmacist (SI). The pharmacy did not sell medicines via its website. People were able to contact the pharmacy via its website.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised, and overall, it provides its services safely. It orders its medicines from reputable sources and manages them properly.

Inspector's evidence

The pharmacy provided its services at a distance. Services were advertised on the pharmacy's website and people were signposted to the pharmacy by their GP surgeries. Leaflets were also posted to people's homes to promote the pharmacy. Some members of the team were multilingual and were observed translating for people calling over the telephone. They were also observed signposting a person to another local pharmacy.

Medicines awaiting collection were stored in a designated area of the dispensary. As people did not collect their medicine, the pharmacist would call them if there were any changes to their medicines or if a new medicine was supplied. They were also signposted to the New Medicine Service, if appropriate. Baskets were used throughout the dispensing process to separate prescriptions and prevent transfer of medicines between people. Dispensed and checked-by boxes were used by team members to ensure that there were dispensing audit trails. Dispensed CDs and items requiring cold storage were stored inside clear plastic bags. This allowed for an additional check when handing out to the delivery driver.

Team members said that they had read the MHRA guidance on sodium valproate and were aware of the need to dispense this medicine in its original packaging. People taking valproate were provided with alert cards. The pharmacist said that they contacted people taking other high-risk medicines, such as warfarin and methotrexate, to check if they were being monitored. These calls were not documented to help maintain clear audit trails.

There were clear audit trails for the multi-compartment compliance pack service. Once prescriptions were received, they were reviewed by the pharmacist. Any changes were confirmed with the GP. Stock was checked by the pharmacist before the packs were assembled by the dispenser. Prepared packs observed were labelled with product descriptions and patient information leaflets were seen to be supplied.

The pharmacy kept a record of what medicines were being delivered in case of any queries. The delivery driver annotated the delivery log with details of the person who had accepted the package, and people were asked to sign to confirm receipt of CDs. Medicines were returned to the pharmacy if the person was not at home.
In-date patient group directions (PGDs) were available for the Pharmacy First service. The service was carried out either virtually or over the telephone. The pharmacists had completed all the relevant training. They maintained the relevant records when providing the service and updated the electronic system as soon as a supply was made. Checklists and flowcharts were easily accessible to the team. The pharmacy had mainly provided advice and over-the-counter remedies to people accessing this service.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. Medicines were stored in an organised manner in the dispensary and were kept in their original packaging. The pharmacy team

checked the expiry dates of medicines at regular intervals and kept clear records of these checks. There were no date-expired items found in with dispensing stock. Fridge temperatures were checked and documented daily. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. And the pharmacy maintained audit trails of recent recall notices it had received. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy was closed to the public which helped to protect people’s personal information. A shredder was available. Computers were password protected. And team members had access to up-to-date reference sources online. The pharmacy had several glass measures and tablet counting triangles. The pharmaceutical fridge was clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively.

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.