General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: 121 Pharmacy, Unit 1 Caxton Park, Caxton Road, Elms Farm Industrial Estate, Bedford, Bedfordshire, MK41 0TY

Pharmacy reference: 9011211

Type of pharmacy: Internet / distance selling

Date of inspection: 08/09/2021

Pharmacy context

The pharmacy is on an industrial estate in a building containing another business owned by the same owners. The pharmacy itself is the ground floor in the building. It offers an NHS dispensing service at a distance as well as dispensing private prescriptions and selling some over-the-counter medicines online. This inspection was undertaken during the COVID-19 pandemic.

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

Members of the pharmacy team work to professional standards and identify and manage risks effectively. They record mistakes they make during the dispensing process. And they try to learn from these to avoid problems being repeated. The pharmacy generally keeps its records up to date and these show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members keep people's private information safe.

Inspector's evidence

There were two main parts to the pharmacy's activities; NHS dispensing services and supplying over-the-counter medicines via a third party online marketplace. Its NHS dispensing service was mainly monthly repeat prescriptions. People would order prescriptions with their own GPs, and the prescriptions arrived electronically at the pharmacy. The dispensed medicines would be delivered by the pharmacist or posted to the person using Royal Mail if outside the local area. There was a very small number of people receiving their dispensed medicines in multi-compartment compliance packs. The prescriptions for these were ordered by the pharmacy team and the packs were sent using the Royal Mail Track and Trace service.

The written procedures said the team members should log any mistakes they made which were corrected during the dispensing process in order to learn from them. They logged any issues and discussed learning from these events. The other pharmacy activity was supplying online orders of over-the-counter (OTC) medicines through a third-party selling platform. This process had been changed following the previous inspection. Laxatives had been removed from the online offer and all the lines advertised had been reviewed with patient safety in mind. A risk assessment had been done about these sales specifically and was under constant review.

The pharmacy displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. There were no controlled drugs (CDs) kept on the premises, and so the controlled drugs registers were blank. No private prescriptions had been dispensed.

The pharmacy had standard operating procedures (SOPs). The SOPs covered the services that were offered by the pharmacy for NHS dispensing. Supplies of OTC medicines were still a large part of the business and were usually online. These sales involved supplies of General Sales List (GSL) medicines. Before opening the pharmacy, the superintendent pharmacist (SI) had identified some medicines which could be used inappropriately and had decided not to sell these. Since the last inspection the items that had previously been offered for sale and could be misused had been removed from sale. There was a system in place to highlight people who had made previous purchases. The pharmacist was reviewing the software of his own website to ensure that he complied with all the current requirements for the safe sales of medicines.

The pharmacist and dispenser had both undertaken safeguarding and confidentiality training at a suitable level for their roles and had access to the local telephone numbers to contact the safeguarding boards, if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively.

Inspector's evidence

The regular pharmacist and dispenser were present during the inspection. They were working together well and, given the small volume of pharmacy work, the team of two dealt with it in a timely manner. The dispenser had completed the relevant training course when working at another pharmacy. The team had regular informal training from the pharmacist. Staff had not had formal appraisals. However, the pharmacy team worked together all the time and feedback about improvements to its processes could be discussed within the team at any time.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare. The pharmacy has adequate security. The pharmacy's own website displays all the necessary information for people. But it is harder for the pharmacy to maintain all the same information on sites operated by third parties.

Inspector's evidence

The pharmacy was clean, tidy and bright. It was situated in a shared building to which the other occupants shared the front door access. The dispensary area was adequate for the volume of prescriptions dispensed. And there was enough bench space for dispensing prescriptions safely. Each member of staff had their own workbench allowing them to socially distance from each other most of the time. The prescriptions were dispensed on one side of the room and the rest of the room was hoped to be used for other services in the future. The OTC stock was kept in the warehouse. This had allowed more room for other services from the dispensary.

The pharmacy's own website allowed people to register the pharmacy as their nominated one so that electronic prescriptions could be directly sent to them. There was no prescribing service associated with this website. The name and address of the pharmacy, the name of the superintendent pharmacist and the telephone number of the pharmacy were all conspicuously displayed on the site. The pharmacy also used a third-party online marketplace to sell medicines. The SI had added his name to every listing on the online marketplace to ensure that it was available to anyone purchasing a medicine, but the third-party site would not let the pharmacy display its telephone number. But it was clear to the customer who was supplying the medicines, and that the medicines were from a registered pharmacy.

Staff had access to toilet facilities which had suitable handwashing facilities. And the dispensary had its own sink, with hot and cold running water. The premises were secure.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner and it gets its medicines from reputable sources. The pharmacy no longer sells medicines over the internet which are liable to abuse.

Inspector's evidence

The pharmacy dispensed medicines for mostly NHS patients. The prescriptions were received electronically and were ordered by the patient. The use of baskets helped to ensure that orders and prescription items were kept together and were easy to move from one area of the pharmacy to another. Computer-generated labels attached to dispensed medicines included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced.

Prescriptions were ordered by people directly from their surgeries, except those receiving multi-compartment compliance packs, but some people asked to be reminded to do so, so that they would not run out of their medicines. When people taking higher-risk medicines such as warfarin, lithium or methotrexate were reminded to reorder their prescriptions, they were asked about any recent blood tests. Some people chose to send information about their blood test results to the pharmacy's mobile telephone via an electronic messaging application, and others told the pharmacist about their latest results. These results were checked to assess if they were current, and within the range expected, and that the dose being ordered complied with the dose the person needed to take. So, the pharmacy could show that it was monitoring these patients in accordance with good practice. There were no people in the at-risk group receiving prescriptions for valproate but the pharmacist knew that they should be routinely counselled about pregnancy prevention. And appropriate warnings stickers were available for use if the manufacturer's packaging could not be used.

A few people were being supplied their medicines in multi-compartment compliance packs. The packs were labelled with all the information the person needed to take their medicines in the correct way. The packs had advisory warnings and cautionary labels on them. The packs had descriptions of the different medicines to identify them.

Sales of OTC medicines were made through a third-party marketplace. There was a questionnaire for people to complete in order to purchase the medicines. The pharmacist said it was difficult to follow up any answers to get more clarification from the purchaser on the third-party sites, so he had stopped selling P medicines or those liable to abuse. He said that he had standard reasons for refusal which he would send to people when this was done. For example, the reason given might be 'too many items ordered'. But the pharmacist said that he had little opportunity to give extra information about products, other than what was published on the website. And he had generally little input into their supply, as OTC orders were picked from the warehouse by the dispenser who then packed the items ready for posting. The pharmacist was in the process of making a new website with better controls on sales. Bought or dispensed medicines were delivered either by the pharmacist or by Royal Mail.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. Regular date checking was done. No out-of-date medicines were found during the inspection. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross-contaminate other tablets. Electrical equipment was due to be tested. Stickers were affixed to some electronic equipment and displayed the next date of testing.

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.