General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: PillSorted, Carthouse 3, Copley Hill Farm Business Park, Cambridge, Cambridgeshire, CB22 3GN

Pharmacy reference: 9011258

Type of pharmacy: Internet / distance selling

Date of inspection: 09/12/2020

Pharmacy context

The pharmacy is in a business park and has a distance-selling NHS contract. It provides NHS and private prescriptions dispensing, mainly to local residents, although some people are from out of the area. The team also dispenses medicines in multi-compartment compliance packs for some people and supplies over-the-counter (OTC) medicines mostly to its regular prescription customers. The pharmacy was visited 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	4.1	Good practice	The pharmacy routinely provides people with additional information to help them get the most out of their medicines. It also keeps people's own GPs informed when it has to make emergency supplies of medicines.
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, including those associated with the COVID-19 pandemic. They are clear about their roles and responsibilities. They record any mistakes they make during the pharmacy's processes. And they take steps to avoid mistakes being repeated. The pharmacy keeps its records up to date although some required by law are not in an easily accessible format. It manages and protects information well and it tells people how their private information will be used. Its team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). The SOPs covered the services that were offered by the pharmacy. And these had been reviewed regularly since the pharmacy opened one year before the inspection. They were signed by the pharmacy's team members to indicate they had been read. The written procedures said the team members should record any mistakes in the dispensing process in order to learn from them. They were regularly logged, although some mistakes which had left the pharmacy had been recorded as near misses rather than dispensing errors. So, any learnings or changes made by the pharmacy as a result of a dispensing error had not been recorded or passed on to the national reporting system. The superintendent pharmacist (SI) and the responsible pharmacist discussed ways to make improvements to the pharmacy's processes on a regular basis.

There was a SOP for working during the COVID-19 pandemic, and the staff had each had a risk assessment to gauge their own personal risk. All the staff present were wearing face masks, and were seen to wash their hands, or to use alcohol hand gel frequently. The pharmacy conspicuously displayed the responsible pharmacist notice.

The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when needed. Feedback from customers was mainly received on Trustpilot and Google. This had led to more synchronisation of prescriptions, ensuring that each person's medicines could be ordered at the same time, and offering a supply of OTC medicinal and non-medicinal products at the same time as the prescription delivery. For example, toothpaste as a monthly delivery.

The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies on their bespoke computer systems when dispensing them. But the information required by law was not easy to find, or in one place. A workable solution was discussed. The controlled drugs registers were kept in book form and were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. Fridge temperatures were recorded daily and were within the recommended range for storing medicines.

Confidential waste was separated and shredded. NHS cards, used to access electronic NHS prescriptions and other information, were not shared and staff had their own terminals which they logged off from when not using. The staff had received training about the General Data Protection Regulation (GDPR) and general information governance. All people using the service were given information about how their details would be used and stored.

The pharmacist had undertaken formal training about safeguarding and the staff had done in-house training on the matter. They were aware of who they should contact if they thought there might be an issue and had the local contacts for the safeguarding boards in the area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training, or are working towards them, to deliver services safely and effectively. And they receive support to keep their skills and knowledge up to date.

Inspector's evidence

There were two regular pharmacists, a dispenser and a trainee dispenser present during the inspection. There was also a delivery driver who had completed the relevant NPA training course.

Generally, the dispenser supervised and packed the OTC sales from the pharmacy and helped with dispensing, while the trainee dispenser was only involved in dispensing, at the time of the inspection. The pharmacist checked the dispensing and helped train the trainee dispenser. He and the SI telephoned the people to remind them to order their prescriptions and checked the OTC sales when required.

The superintendent pharmacist (SI) and the pharmacist regularly had discussions about how to improve the services provided. As well as talking to the staff about the way they worked as a team. There had been changes in the systems used as a result of these discussions. The way they acted on faxed prescriptions had been changed as a result of some of the discussions. A formal appraisal process was being put in place now that the business was a year old.

The dispenser had come from another pharmacy and had completed her certified training. The other member of staff had been in post for 10 days and was already enrolled on the NPA training course. There was a variety of in-house training set up for the pharmacy's systems to ensure that the whole team complied with the processes in the pharmacy. There were no targets set for the staff.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

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 pharmacy had adequate security. 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 now had their own workbench allowing them to socially distance from each other most of the time. This had been implemented as a result of COVID-19 assessments. The prescriptions were dispensed in one room and the OTC products were packed and supplied from another.

The website allowed people to register the pharmacy as their preferred one so that electronic prescriptions could be sent to this pharmacy. There was also a shop which sold OTC medicines, including some pharmacy-only (P) medicines. The person would select the product, and the person would be telephoned to ensure the product's suitability before the purchase was finalised and sent to the purchaser. There with quantity limits on some lines. There was no prescribing service associated with this website. The name and address of the pharmacy, the name of the SI and the telephone number of the pharmacy were all conspicuously displayed on the site as well as the EU logo.

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

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. And it gets its medicines from reputable sources. The systems for monitoring higher-risk medicines on prescription are robust. The pharmacy has some processes in place to monitor its sales of medicines. But because it doesn't keep records about this, it is harder for the pharmacy to demonstrate how its systems protect the health and wellbeing of people who use the pharmacy.

Inspector's evidence

The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary 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.

When a new person asked for their medicines to be dispensed by the pharmacy, a pharmacist would telephone them to ask about how many doses they had left at home and the times of day they took their medicines. The person would then be allocated a week in the four-weekly cycle in the dispensary. The information would form the basis of the patient information chart which the pharmacy produced. This summary was sent to the person to use as a repeat medicine request form and as a daily reminder about their medicines and when they should take them. This document had pictures of the medicines, taken from TicTac or other sources, and was kept up to date by the team. If the person required more help, a medicines administration chart (MAR chart) could be supplied. The charts were provided for each person in the care homes the pharmacy supplied.

The pharmacy team members (usually the pharmacists) reminded people when they needed to order their prescriptions. They had helped some to get their prescriptions synchronised and put onto the electronic repeat dispensing service. If a prescription had not been received in time for the person's next supply, the pharmacy would give an emergency supply, and inform the surgery by email that this had been done. The team sent out health promotion leaflets regularly, including the NHS 'Stay Well this Winter' and their own 'Educational Snippets'.

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 their results letter to the pharmacy's mobile telephone via WhatsApp, and others told the pharmacist about their latest results. So, the pharmacy could show that it was monitoring these patients in accordance with good practice. People in the at-risk group who were receiving prescriptions for valproate were routinely counselled about pregnancy prevention. But appropriate warnings stickers were not available for use if the manufacturer's packaging could not be used. The SI said that she would get some of these immediately.

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 also had photographs of the different medicines to identify them more easily.

Sales of OTC medicines were mainly made to users of the dispensing service. Quantities sold through

the shop were very small. Each purchaser was contacted by telephone by the pharmacist following a request to purchase a P medicine. The range of these was very small, but it relied on the dispenser knowing that a medicine was a P line and telling the pharmacist. The SI said that she would review the software for the invoicing of P medicines, but in the meantime the pharmacist would monitor all sales through the on-line shop. There were no records kept of the conversations between the pharmacy and the purchaser and the pharmacy could not demonstrate why and whether it had refused any sales. Medicines were either delivered in person by the delivery driver to local people, or they were sent by Royal Mail using the Track and Trace service.

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 and advice 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. If there was a problem with the internet at the premises there were contingency plans in place, such as using a hotspot to prevent any disruption of medicines supplies to people. This had been tested to check that it did work.

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.