General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pillo, Unit 25, Oakhill Trading Estate, Devonshire Road, Worsley, Manchester, Greater Manchester, M28 3PT

Pharmacy reference: 9011300

Type of pharmacy: Internet / distance selling

Date of inspection: 28/09/2021

Pharmacy context

This is an online pharmacy which members of the public could not enter. People would access the pharmacy's services through their website http://www.pillo.co.uk and their medicines would be delivered to their door. It is situated in an industrial estate near Worsley in Manchester. The pharmacy dispenses NHS prescriptions and some private prescriptions. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time.

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
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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. Members of the team are given training so that they know how to keep private information safe. And they discuss things that go wrong to help avoid making the same mistakes again. But they do not always make records of this so they may miss some opportunities to learn.

Inspector's evidence

There was a current set of standard operating procedures (SOPs) and their stated date of review was July 2022. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

There was a paper log to record any near miss incidents. But few incidents had been recorded during August and September 2021. The superintendent (SI) admitted he did not think all incidents had been recorded. He explained how he reviewed the records and discussed any learning points with members of the pharmacy team. But he did not keep any records of this. He would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. Examples of action that had been taken to help prevent similar mistakes were provided. These included moving similar strengths of Lansoprazole oro-dispersible tablets away from one another and highlighting the location of paracetamol stock to remind staff to check the formulation. An error report form was available for any dispensing errors which had been reported to the pharmacy. The SI described how he would make a record and investigate any errors but said none had been reported to him since the pharmacy had opened.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what his responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. Any complaints were recorded and followed up by the SI. A current certificate of professional indemnity insurance was on display.

The RP was appropriately signed into the RP log. But he routinely did not record the time he finished. So the pharmacy may not always be able to show when a pharmacist was present. Controlled drugs (CDs) registers were maintained with running balances recorded. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register. Records of unlicensed specials were in order.

An information governance (IG) policy was available. The pharmacy team completed IG training and had signed a confidentiality agreement in the IG folder. When questioned, the trainee dispenser was able to show where confidential waste was segregated to be removed by a waste carrier. A privacy notice was on the website and explained how people's data was handled by the pharmacy.

Safeguarding procedures were included in the SOPs and the pharmacy team had completed safeguarding training. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said he would initially report any concerns to the pharmacist on duty. He also knew where to find the contact details if there was a safeguarding concern for a patient who did not live locally.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist – who was also the SI, and two dispensers – one of whom is in training. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by locum dispensers and a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about telephone communication skills. Training records were kept showing what had been completed by each member of the team. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

When questioned, a dispenser gave an example about how he would refer a patient query to the pharmacist if he felt the patient would benefit from some additional counselling. The trainee dispenser said he felt he received a good level of support from the pharmacist and was able to ask for further help if he needed it. The staff held a morning team meeting about issues that had arisen, including when there were errors or complaints. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no professional based targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and steps have been taken to make the premises COVID secure. There is sufficient information on the pharmacy's website for people to know who is providing the pharmacy services.

Inspector's evidence

This was a closed pharmacy which was not accessible by members of the public. It had a website which people would use to find out information about the pharmacy and its services. It contained details about the company, the SI and the pharmacy's location.

The dispensary was a purpose-built unit within a warehouse unit. It was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. The temperature in the dispensary was controlled by the use of an air conditioning unit. Lighting was sufficient. The staff had access to a kitchenette and WC facilities. Members of the pharmacy team had access to masks and hand sanitiser. A COVID SOP was available and had been signed by staff.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible remotely. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. The pharmacy dispenses some medicines in compliance aids to help people take them at the right time. But it does not assess people properly to make sure they will benefit from having the compliance aids. So it may sometimes supply them to people who would be better off having ordinary packs.

Inspector's evidence

The contact details for the pharmacy were available on its website. People were able to access the pharmacy via telephone, email, instant web chat or a contact form on the website. To use the pharmacy's services, people could sign up using the contact form on the website.

The pharmacy used an automated dispensing robot that assembled medicines in a compliance aid system that consisted of individual dose bags, joined together in a long roll in time order. The patient took the medicines from the next bag on the roll each time a dose was due. When a new patient had ordered their prescription, and it was electronically received by the pharmacy, a member of staff would contact them to discuss their requirements. If the patient was taking 3 or more medicines, they would be offered to have their medicines dispensed in a compliance aid. But the pharmacy did not carry out any sort of assessment to decide whether the patient would benefit from having their medication dispensed into the compliance aid. Details about the medication the patient was taking, and the time to dispense it were recorded on the patient medical record (PMR).

Stock medicines were loaded into the dispensing robot either in bulk canisters, or batch trays. The batch trays were used to allow 'one off' or unusual medicines to be inserted into the machine when needed. Patient information leaflets (PILs) were not supplied with compliance aid dose bags unless they were requested by the patient. So people may not always have up to date and full information about how to take their medicines safely.

Any medicines which could not be dispensed by the robot would be assembled by a dispenser in the original pack or a conventional container. The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. Once all medicines had been assembled as required by the patient, the pharmacist would complete a final accuracy check. This included a visual accuracy check of medicines in each of the compliance aid dose bags.

Some medicines were dispensed for residents of care homes. The care home would provide the pharmacy with information about which medicines were required for each patient. When prescriptions were received back, the pharmacy would check off each medicine on the sheet. Any outstanding prescriptions were chased up by the pharmacy with the patient's GP surgery. Any unresolved queries would be referred back to the care home to be followed up.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a paper delivery record was kept for local deliveries as an audit trail. Unsuccessful deliveries would be returned

to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. Any national deliveries were sent using Royal Mail tracked services. If a medicine required refrigeration, the pharmacy used WoolCool insulated packages. The manufacturer had provided the pharmacy with information to show the packages had been verified. The SI had also conducted various tests to ensure they maintained a suitable temperature for the delivery of medicines. A delivery risk assessment had been completed. The SI was able to explain how he would deal with a concern about a delay in the delivery of a fridge medicine.

There were processes in place to check any prescriptions containing schedule 3 or 4 CDs were valid at the time of supply. But there were no processes to audit or check whether patients taking high-risk medicines (such as warfarin, lithium and methotrexate) had been counselled about the risks and monitoring requirements. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to provide when the medicines were supplied. The pharmacist said he would speak to patients to check the supply was suitable but that there were currently no patients meeting the risk criteria. Steroid alert cards were available to give to patients who needed them.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Medicines for the robot were de-blistered from their original packs and stored in bulk pots. The bulk pots had the batch number and expiry date of the de-blistered medicine, and the date they were de-blistered. The pharmacist said they would only de-blister enough medicines to use within a 28-day period which he had checked using the NHS Specialist Pharmacy Service (SPS) website to ensure they could be stored in such way. Any medicines over the 28 days would be discarded.

The bulk pots were used to refill the canisters within the robot. Specific brands of medicines were ordered to fit in specific canisters. These were of a particular size to ensure the tablets could 'sit' within a drop channel, which was how the robot controlled dispensing the medicine into the individual dose bags. When a medicine of a different brand had a different shape or size, the staff would calibrate the robot to ensure the canister was suitable and worked correctly. But there were no records to show when this was completed.

Stock was date checked on a 3-monthly basis. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Any short dated stock was highlighted using a sticker and removed at the start of the month of expiry. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use.

There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had remained in the required range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. Alerts were printed, and details about the action taken, when any by whom were written onto a sheet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had equipment for counting loose tablets and capsules, including tablet triangles, a capsule counter and a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

The dispensing robot was cleaned by members of the pharmacy every two to three days depending on usage. But there was no log to show when this had been completed. So the pharmacy may not be able to always show what had been completed and by whom in the event of a query. In the event of a maintenance issue, the pharmacy could contact the manufacturer for advice and technical support.

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.