General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Target Pharmacy, 8 Redwood Crescent, East Kilbride, Glasgow, South Lanarkshire, G74 5PA

Pharmacy reference: 9011306

Type of pharmacy: Internet / distance selling

Date of inspection: 21/08/2023

Pharmacy context

This is a small internet-based pharmacy situated within a larger wholesaler's premises in a business park in East Kilbride. It provides specialist dispensing services for the supply of a limited range of medicines, many of which are unlicensed, and known as 'specials.' People do not enter the pharmacy premises to obtain their medicines, instead the pharmacy arranges delivery.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy has not completed robust risk assessments for all of its services. This includes aesthetics products, including botulinum toxins, and unlicensed controlled drugs. And it is not able to show that the risks associated with supplying these treatments are being effectively managed.
		1.2	Standard not met	The pharmacy does not proactively audit or review the quality and safety of its services. It does not have adequate systems in place to identify trends to prompt effective interventions. There are no systems to audit the higher-risk and higher volume medicines it supplies. And no systems to effectively identify and challenge overprescribing and oversupply.
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 not all met**

Summary findings

The pharmacy does not meaningfully assess and manage all the risks associated with its services. It doesn't complete risk assessments for all its services and the higher-risk medicines it supplies. And it doesn't review or monitor its services to ensure it provides them safely. The pharmacy relies on the people using its services following its terms and conditions. But its processes are not robust enough to identify and challenge when these are not followed. Which means that people can sometimes obtain medicines that may not be suitable for them. The pharmacy keeps the records it should. And it keeps people's private information secure and understands how to protect vulnerable people.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. SOPs included publication and review dates and were version controlled. SOPs were currently being reviewed by the Superintendent Pharmacist (SI). The pharmacy had completed a general risk assessment (RA) covering some of the activities and regulatory requirements of providing a private dispensing service. And it had a risk assessment for providing medicines for clinical trials. But it had not completed specific risk assessments relating to the two main services it provided. These were providing specific unlicensed controlled drugs (CDs) which were higher risk; and providing non-surgical cosmetic treatments including medicines and associated products for aesthetic procedures. Some of the risks involved in supplying these medicines had not been suitably identified by the pharmacy.

The SI explained that although there was not a documented RA for providing specific CDs, they completed checks before supplying medication for these clinics. They checked that the medicine was prescribed by a doctor on the GMC specialist register, or by a prescriber working with the specialist under a shared care agreement. But they did not always carry out regular checks to ensure prescribers remained registered to prescribe. And they did not routinely check the regulation of the clinics where the prescribers were based. The pharmacy had dispensed prescriptions from a prescriber working independently from a non-regulated clinic address. The pharmacy had not checked the status of the clinic and had not been provided with prescribing policies or procedures. So the pharmacy could not be assured that the clinic was working to the required standards. Deliveries of these medicines were usually made to the address stated on the signed prescription. The pharmacy did not use electronic verification checks to confirm people's identify. But people could nominate an alternative address by written request to the pharmacy. The pharmacy had not assessed the risk of supplying higher-risk controlled medicines to an unverified address. This is particularly a risk for medicines that are liable to abuse, misuse and overuse.

The pharmacy carried out checks on prescribers and practitioners ordering aesthetics products when they registered with the pharmacy. This included checking photographic ID, their professional registration status, and any associated websites. They did not request evidence of training or indemnity insurance. There were multiple examples of dispensed prescriptions for prescription-only-medicines (POMs) with unusually large quantities of aesthetic treatments. Such quantities would be inappropriate to administer to a single person. The pharmacy had dispensed and supplied them without any intervention being made by the pharmacy team to challenge why the medicine or treatment had been ordered for a large quantity, and if the medicines were intended for treatment of one person, or for use as stock to treat other people. Non-medical practitioners should only administer POMs if they have

been prescribed for the named patient. This meant that practitioners could be administering POMs to people without the correct legal authority to do so, and without the pharmacy being assured that people were old enough for the treatment or that they had been physically examined by the prescriber. The terms and conditions on prescriber registration stated "I confirm the items prescribed will only be used for the treatment of the patient named on the prescription" so this demonstrated a disregard for the terms and conditions by the people using the pharmacy, but also by the pharmacy team. The pharmacy's SOP for dispensing non-surgical medicinal products stated that the pharmacy would not dispense more than five injectable cosmetic products per prescription. But there were multiple examples of prescriptions being dispensed with quantities over double this. So the pharmacy team was not following the agreed procedures. The procedure did not provide guidance as to acceptable frequencies for these products.

The pharmacy had not completed any clinical audits related to the supply of medicines through its service. And without specific information about the prescribing from the clinics, it would find it difficult to assess the findings of any audit. They did not monitor day-to-day performance of the pharmacy's services against a known standard, a key requirement in a clinical audit. This included identifying and managing overprescribing and supply of products, especially those liable to misuse. The pharmacy submitted the private CD prescriptions to the NHS Scotland Practitioner Services every month as required, so there was external visibility of prescribing activity. But any prescribing data generated through following this process would not be shared with the pharmacy.

The pharmacy had tools to support its team members in recording mistakes found and corrected during the dispensing process, known as near misses. But there were no records of any near misses being recorded. Team members explained this was down to the low volume of business and affording team members the time to dispense accurately. Pharmacy team members understood how to respond to, and report mistakes identified following a person receiving their medicine, known as dispensing incidents. The SI was able to explain how they had changed their process to keep prescriptions with multiple items together and reduce the chance of delivery error after a previous incident. But they had not formally recorded or documented the action taken following this incident.

The pharmacy had current indemnity insurance. It displayed the correct responsible pharmacist notice and had a digital responsible pharmacist (RP) record. But a sample of records identified that the RP sometimes signed in for a full day when they had only been present from later in the day. This meant RP records did not always reflect accurate timings associated with the RP role. Team members only worked in the pharmacy when an RP was present. The pharmacy kept complete records for unlicensed medicines. The pharmacy kept digital CD records with running balances. A random balance check matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

The pharmacy had a procedure for managing feedback and complaints. And it provided clear information on its website about how people could contact the pharmacy. Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure destruction. Pharmacy team members completed training on General Data Protection Regulation (GDPR). The pharmacy had a procedure for safeguarding vulnerable adults and children. And this contained local contact details if team members had concerns. The pharmacist was registered with the protecting vulnerable group (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications for their roles and the services they provide. They complete training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and concerns.

Inspector's evidence

The pharmacy opened for only a few hours each day. It employed one part -time pharmacist and a part-time dispenser which was sufficient to manage the current workload. The SI was available for team members to refer to when needed. And they were able to work flexibly providing contingency for absence. The SI reviewed staffing hours and explained that they were recruiting another dispenser to allow extra cover. The pharmacy occasionally used locum pharmacists to cover absence, for example annual leave.

The pharmacy maintained a training portfolio with evidence of qualifications and regular e-learning completed by its team members. When locum pharmacists started with the pharmacy, they were required to undertake a minimum of period of one week shadowing the RP and team members. They were also required to complete specific training to allow them to understand the clinical considerations of providing specific controlled drugs. This helped ensure they had sufficient knowledge to carry out appropriate clinical checks. Pharmacy team members were knowledgeable about the types of products being dispensed and understood processes required by law when dispensing the specific CDs for the private service.

The pharmacy provided protected training time in the workplace. And this had supported team members when completing qualification training coursework. Team members attended an annual appraisal of performance. This helped them to identify developmental needs to provide a safe and effective pharmacy service. The pharmacy team discussed mistakes and dispensing incidents and how to reduce risks. The team had regular team meetings with the SI.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the provision of the specialist healthcare services provided. They are clean, secure, and well maintained. The pharmacy's website provides clear information to people about the pharmacy's registered status.

Inspector's evidence

The pharmacy premises were based in a locked area within a larger business building used by the organisation's wholesale company. Access to the pharmacy was restricted by electronic ID cards used by the pharmacy team. It was not possible to access the premises without a team member present. People could access private services online through the pharmacy's website which provided details about the owners, its physical location and contact details. It also provided the names and the registration details of the SI.

The premises provided ample space for its services. They were well-organised and provided a series of shelves and bench space for dispensing. Team members kept the areas neat and tidy and free from congestion. Team members used the dispensary sink for hand washing. And they cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are accessible to people. It makes checks to ensure it obtains its medicines from reputable suppliers. And it generally stores its medicines safely and securely with regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was closed to the public so did not provide access to the premises. People contacted the pharmacy by telephone or email. The pharmacy team would speak to people after receiving their prescription to arrange payment. And this provided an opportunity to discuss additional information, reinforce dosage directions and offer support with the pharmacist.

All prescriptions dispensed for special controlled medicines were on paper NHS CD private prescription forms, known as an FP10PCD. The pharmacy specified that clinics must arrange secure delivery of these via courier. Clinics prescribing medicines for aesthetics used a template to complete a prescription form and this was sent to the pharmacy.

The pharmacy was aware that the prescribing clinics conducted both face-to-face consultations and remote consultations as part of the prescribing process. It checked the registration of medical doctors to ensure they were on the General Medical Council's (GMC's) specialist register as required. And prescribers' professional registration was checked to ensure they were authorised to prescribe. The SI reported that the pharmacy completed checks before partnering with the clinics. They requested professional documents such as proof of indemnity insurance, ongoing training by doctors and non-medical prescribers, clinic risk assessments, prescribing policies, and inspection reports from the clinic's regulator. But they had not received risk assessments or prescribing policies from all the clinics. The pharmacy did not request any information relating to the condition that the medicine was prescribed for. And they did not have access to the clinical record. This meant the pharmacy had no way of verifying if the clinics were continuing to prescribe only for the conditions stated in the prescribing policies. The pharmacy required prescribers to confirm that people had received a physical face-to-face consultation with their prescriber when receiving prescriptions for botulinum toxins, in accordance with current guidance published by the Joint Council for Cosmetic Practitioners (JCCP) and the GPhC. But it did not make any further checks after initial registration of the clinic to ensure that this had occurred.

On receipt of the paper prescription, a pharmacist completed a basic clinical check to ensure that the prescription was appropriate. The RP was able to describe making interventions on prescriptions, for example to query an unclear dose on a controlled drug prescription. But they did not record these. The pharmacy received some prescriptions for aesthetics medicines with the directions "Use as directed." The lack of directions or information about administration made it more difficult for the pharmacists to determine if the supply was appropriate, and the lack of clear instructions increased the risk of inappropriate use. When the patient had paid for the prescription, it was then released for dispensing. The dispensing team member completed labelling and assembly tasks prior to medicines being accuracy checked by a pharmacist. Pharmacy team members used appropriately sized baskets throughout the dispensing process to reduce the risk of medicines and prescriptions becoming separated. Separate baskets were used for each person's medicine to help prevent the risk of mix up. The team supplied all medicines in original sealed containers. Pharmacy team members completed a dispensing audit trail by

signing their initials in the ‘dispensed by’ and ‘checked by’ boxes on medicine labels. People receiving unlicensed medicines did not receive manufacturer’s information leaflets with the products due to the unlicensed nature of the medicines. Dispensing and product labels included information about the risks associated with driving under the influence of the medicine. The team packaged the medicines securely with a clear address label and tracking ID and held the packages securely until collected by the courier. The pharmacy had clear audit trails relating to the delivery process. And medication was only supplied to UK addresses.

The pharmacy obtained medicines from recognised suppliers and from licensed specials suppliers. And kept records relating to the batches of medicines supplied to individuals. It stored medicines in their original packaging on shelves. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy held stock of CDs securely and storage within the secure cabinet was orderly. It stored items requiring cold storage in a fridge. The pharmacy used electronic data logging systems to continually monitor the temperatures. The system alerted the SI 24 hours a day if a temperature was outside of expected ranges. The temperature records seen were within acceptable limits. Team members were aware of the appropriate action to take if these went above or below accepted limits. The team completed regular date checking tasks and it routinely checked expiry dates during the dispensing process. The pharmacy maintained a stock database to highlight any products that were due to expire so that they could be removed appropriately. The pharmacy had an effective system for receiving and acting upon medicine alerts issued by the MHRA.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

Team members had access to up-to-date electronic reference resources and internet access allowing access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy team kept clean tablet and counters in the dispensary. Higher-risk controlled medicines were dispensed in original packs so did not require measuring equipment. The pharmacy used discreet packaging for deliveries. This meant that people were unable to identity the medicines that were contained within.
The pharmacy stored paper records in cabinets within the dispensary which was inaccessible to people. It stored prescription forms waiting to be dispensed in a locked filing box when the pharmacy was closed. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.