General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The PharmPet Co, Unit 7 Stirlin Point, 7 Sadler Court, Sadler Road, Lincoln, Lincolnshire, LN6 3RG

Pharmacy reference: 9011339

Type of pharmacy: Veterinary

Date of inspection: 02/09/2021

Pharmacy context

The pharmacy is on an industrial estate, on the outskirts of Lincoln. It operates a distance selling model. This means members of the public do not attend the pharmacy in person but instead access the pharmacy's services through its website. The pharmacy specialises in supplying veterinary medicines. It is registered with the Veterinary Medicines Directorate (VMD) Accredited Internet Retailer Scheme (AIRS). The pharmacy also supplies Prescription Only Medicines (POMs) against prescriptions written by veterinary practitioners for the treatment of animals under the 'cascade'. The pharmacy was inspected during the coronavirus 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	Good practice	1.1	Good practice	The pharmacy keeps a comprehensive risk register relating to the full scope of services it provides. The register is reviewed regularly and is used to inform changes to standard operating procedures.
		1.2	Good practice	The pharmacy has good review processes which include regular monitoring of safety incidents. It responds to these incidents effectively and puts controls in place to mitigate risk. These controls are kept under review to ensure they remain effective.
		1.4	Good practice	The pharmacy encourages feedback from service users. And it carefully considers feedback and guidance from regulators to support the safety and quality of its services.
2. Staff	Good practice	2.2	Good practice	Pharmacy team members demonstrate a commitment to ongoing learning. And they identify how extended learning can help in the recruitment and training of new team members as the business develops.
		2.4	Good practice	Pharmacy team members work within a culture of openness and learning. They are enthusiastic about their roles and they work together well to achieve common goals.
		2.5	Good practice	The team is good at communicating through regular discussions and structured meetings. This helps to easily identify and address any concerns. All team members are empowered to use these feedback mechanisms as an opportunity to share ideas. And the pharmacy uses these ideas to inform how it delivers its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Team members apply robust risk management strategies to support the safe supply of higher risk medicines.
		4.3	Good practice	The pharmacy completes effective assurance checks to make sure it obtains

Principle	Principle finding	Exception standard reference	Notable practice	Why
				medicines from reputable wholesalers. It has robust monitoring processes in place from source to supply of a medicine.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy has robust clinical governance processes that clearly identify and manage risks associated with the services it provides. It keeps a comprehensive risk register which it reviews regularly to help monitor risk. And it uses these reviews to inform changes to its procedures. The pharmacy encourages feedback and shows how it uses this feedback to inform the way it provides its services. It holds records securely and in keeping with legal and regulatory requirements. The pharmacy's safeguarding procedures clearly consider the risks associated with the service model in place. And its team members understand how to raise potential safeguarding concerns. Team members actively engage in safety reviews following incidents. And they use these reviews to drive improvement in the safety of the pharmacy services they provide.

Inspector's evidence

The pharmacy had carefully considered the risks of operating its services during a pandemic. This included engagement with the Health and Safety Executive. And a risk assessment related to providing its services during the pandemic. Pharmacy team members had personal protective equipment available and team members could maintain social distancing with ease whilst working. Despite the pharmacy operating a distance selling model it had a copy of the NHS England and NHS Improvement COVID-19 standard operating procedure (SOP) to refer to. This document supported safe working practice in community pharmacy.

The pharmacy had a comprehensive risk assessment. It kept this as a working document known as the risk register. The risk register covered all areas of the service provision. And included information governance, business continuity, delivery of medicines, dispensing, e-commerce, security and ongoing learning. There was evidence of continual reviews taking place to help identify changes in processes since the pharmacy had opened in March 2020. And the risk register was updated accordingly following such a review. One area relating to the way the pharmacy asked people to confirm they were over the age of 18 prior to using its services was awaiting change on the day of inspection. The pharmacy was required to complete an annual audit of the veterinary medicines it had supplied on prescription. It had completed its initial audit around six months after opening. And had used this as an opportunity to ensure all required data was auditable. The team were preparing to complete the next audit shortly.

The pharmacy's procedures and risk assessments clearly identified how it managed risks associated with the supply of both veterinary medicines and human medicines under the veterinary cascade. The pharmacy supplied the following categories of veterinary medicines. POM-V (products only available with a prescription from a vet and supplied by a pharmacist or veterinarian). POM-VPS (prescription only medicines prescribed and supplied by either a veterinarian, pharmacist or suitably qualified person (SQP)). NFA-VPS (products suitable for non-food producing animals and supplied by a veterinarian, pharmacist or SQP). AVM-GSL (authorised veterinary medicines which have no restrictions for retailers).

The pharmacy had SOPs to support the safe running of the pharmacy. The SOPs included a version number and clear dates of implementation. They did not have a documented review date. But evidence of continual reviews was clear as some SOPs had later version numbers following a review of a process. For example, the repeat dispensing SOP. SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. And training records associated with the SOPs were available for inspection. Workflow was observed to be carried out in accordance

with the detail recorded in the dispensing SOPs.

The pharmacy had both near miss error logs and incident reporting forms to support reporting and learning from any incidents. Pharmacists completed all dispensing tasks and workflow was efficient and highly organised. This reduced the risk of a near miss or dispensing incident occurring. The pharmacy had one incident since it had opened. This had involved a mistake during the dispatch stage of the process which resulted in the wrong name and address on the package. The team had identified the incident prior to the parcel arriving at its destination and had successfully retrieved the parcel prior to it being opened. The pharmacy had reported the incident and had carried out a thorough review of the dispensing process to help identify areas for improvement. In response to the incident the pharmacy team had changed the dispatch process. The new process saw two address labels printed, a team member attached one to the packing slip and one to the parcel. There was a three-way check of the name and address printed on the packing slip, the name and address of the label attached to the packing slip, and the name and address of the label on the parcel during the dispatch stage of the dispensing process. And a second pharmacist checked the packing slip information again against the sealed parcel prior to courier pick up.

The pharmacy held a monthly safety review. This meeting included reviewing any near misses and incidents. It also included sharing information related to any suspected fraudulent prescriptions received. And the team used the discussions to help inform changes to the risk register and SOPs. The team documented this meeting, and it attached monthly near miss and any incident reports to each month's meeting notes. In addition to this meeting the team met weekly when required to discuss any near misses or incidents which had occurred within the last week.

The pharmacy had a complaints procedure and it advertised how a person could provide feedback about the pharmacy on its website. It also subscribed to a consumer review website which sent out random requests for feedback on the pharmacy's behalf. Reviews on this website were extremely positive and highlighted diligence and good levels of customer service provided by the pharmacy team. There was evidence to support the pharmacy had taken onboard feedback and guidance from regulators to inform the management of its services. For example, it had sought feedback from the VMD prior to launching a new interactive tool on its website.

The pharmacy had up-to-date indemnity insurance arrangements in place. A sample of pharmacy records inspected conformed to legal and regulatory requirements. These included the RP notice, RP register and private prescription records for POM medicines supplied under the cascade. The pharmacy's record keeping procedure identified that these records were to be kept for five years. The pharmacy did not supply schedule 2 CDs. But did supply some schedule 3 CDs. It held a record of these medicines and kept a running balance of them. The pharmacy was registered with the Information Commissioner's Office, and one pharmacist led on information governance. All personal identifiable information was held in a lockable cabinet and on password protected computers. The pharmacy held confidential waste securely in labelled bins. The waste was transferred to sealed bags and was collected by a licensed waste manufacturer for secure disposal.

The pharmacists had completed some safeguarding training through the Centre for Pharmacy Postgraduate Education. The pharmacy had procedures in place to support the team in reporting any concerns relating to both vulnerable people and animals. And contact information for human safeguarding agencies and the RSPCA were available within the SOPs. The pharmacists discussed specific learning relating to safeguarding to recognising abuse in animals and humans. And the pharmacy's SOPs referred to a published guide on the subject.

Principle 2 - Staffing ✔ Good practice

Summary findings

A small and highly skilled workforce provides the pharmacy's services. There is a real focus on continual learning and development. And this commitment to learning includes future planning as the business expands. The pharmacy's team members are enthusiastic about their roles. They work effectively together to achieve common goals. And they actively engage in safety reviews and share ideas which they use to inform the way in which the pharmacy provides its services.

Inspector's evidence

Two pharmacists and a retired pharmacist worked at the pharmacy. Both pharmacists were directors of the business, with one appointed as Superintendent Pharmacist (SI). SOPs provided information relating to job roles and responsibilities. The retired pharmacist was no longer on the GPhC register. They worked in a support role and did not undertake tasks associated with the supply of POMs. Both pharmacists worked fulltime in the pharmacy and had not taken time off since the pharmacy had opened in spring 2020. They discussed plans for bringing in another pharmacist and/or a SQP prior to taking planned leave.

Both pharmacists were highly committed to ongoing learning and development. This included accessing bespoke monthly veterinary pharmacy learning and general training modules through an e-learning platform. Both pharmacists were enrolled on SQP training through the Animal Medicines Training Regulatory Authority (AMTRA). They were exempt from requiring registration as a SQP due to their pharmacist registration status. But had enrolled on the course to support their own knowledge and skills. And they planned to use their experience of the course if the pharmacy went on to employ a SQP as the business developed. The pharmacy did not have targets in place for the services it provided. Pharmacy team members demonstrated how they applied their professional judgement in the best interests of the owners and their animals. For example, pharmacists checked prescriber credentials for every prescription received.

Communication between team members was continual. The pharmacy had an established meeting schedule to support team members in discussing key topics and in reviewing key documents. The schedule included risk review meetings, SOP review meetings, near miss and incident review meetings, safety reviews and regular operational meetings. This protected meeting time helped to ensure the ongoing safety of the pharmacy's services was monitored. The team also regularly reviewed workflow in the pharmacy and had shared ideas about how to use the space moving forward. One pharmacist was leading on creating a lean working model involving individually equipped workstations to support the business as it expanded.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. The premises are well maintained, and they offer a suitable environment for providing pharmacy services.

Inspector's evidence

The pharmacy was secure and maintained to a good standard. The premises consisted of a large dispensary with workstations assigned to different stages of the dispensing process. It had enough shelving for holding medicines and pet supplies. There was an office to the side of the dispensary as well as staff kitchen and toilet facilities. The pharmacy did not advertise or sell any POMs through its website. The website displayed the VMD's AIRS logo which included the pharmacy's individual registration number for the scheme. The website provided the GPhC registration details of the pharmacy and the SI. And included specific information about the authorisation and classification of veterinary medicines.

Team members completed regular cleaning tasks and a rota was in place to assist with this. Lighting was sufficient throughout the premises. An electric heater was available and suitably positioned away from stock holding areas. Pharmacists had completed temperature monitoring during winter months to ensure the heat provided was adequate. A thermometer monitored room temperature, and the pharmacy had an arrangement in place with a local air-conditioning firm if it required a temporary air conditioning unit during summer months. The shutter at the front of the industrial unit was open on the day of inspection. This provided good ventilation throughout the premises and portable metal screening was positioned across the entrance left by the shutter to safeguard against unauthorised access into the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are easily accessible. It uses its website to provide helpful information to pet owners. The pharmacy team manages its workload effectively and it follows robust processes when dispensing medicines. Team members apply robust risk management strategies to support the safe supply of higher risk medicines. The pharmacy has effective assurance checks to make sure it obtains medicines from reputable wholesalers. And it has good audit trails in place for each medicine from source to supply. The pharmacy keeps records of the checks it makes to ensure medicines remain safe to use and fit for supply.

Inspector's evidence

People accessed the pharmacy's services through its website or by telephone. The website included an information hub which was regularly updated. This provided helpful information on a range of topics for pet owners. For example, a guide to caring for your pets in hot weather had been published at the beginning of June 2021. The pharmacy did not advertise the supply of medicines via the veterinary cascade, this complied with legal requirements. People wishing to have a prescription dispensed from a veterinary practitioner for the treatment of animals under the 'cascade' were required to ring the pharmacy. A price list for veterinary medicines on the website was detailed and included a data sheet for each medicine. To comply with regulations it was presented in a uniform way with text and images the same size and no product more prominent than another. And the pharmacy clearly advertised that a prescription from a veterinarian was required for specific products.

Pharmacists had a good understanding of pet owners needs and common misunderstandings around everyday essentials. For example, flea treatments and wormers. It required people accessing the pharmacy's services to complete 'pet profiles'. These profiles assisted with checks during the dispensing process. The pharmacy had recently launched a new interactive tool to guide people's choice when purchasing a wormer. The tool used lifestyle and preference questions to help determine the product, dose and frequency.

The pharmacy had a medicines risk assessment. This had details of every medicine on the price list and was used to determine a risk score for each medicine and what controls were needed for supplying that medicine. For example, it was used to determine whether the pharmacy routinely contacted the prescriber before supply, what delivery schedule could be offered and whether the original prescription was required. The risk assessment helped build the product information profile on the pharmacy's website. And although it only applied to veterinary medicines it informed the way the pharmacy supplied POMs. For example, the need to receive the original copy of the prescription before making a supply. In addition to routinely checking veterinary surgeons details against the RCVS register, the pharmacy often telephoned a practice to clarify or confirm some information. This additional step was routine practice for some medicines such as CDs.

The pharmacy's website warned people that it was an offence to alter a prescription and fraudulently produce a prescription. And it clearly informed people that suspected prescription misuse was reported to the VMD or to the police. Despite this warning the pharmacy had identified and reported prescription fraud to the VMD on multiple occasions. On each occasion the pharmacy had completed an

initial investigation including checks with the prescribing practice. And it had sent a report and had provided the VMD with a copy of the prescription as required. It held details of these reports for its own records and had provided feedback to the people submitting the prescription of the steps it had taken to prevent fraud.

The dispensing workflow was efficient. Details of orders, including prescriptions were held with packing slips and pet profiles in individual baskets on designated shelves for each step of the dispensing process. And different shelves in the same area were used for different categories of medicines. Once a prescription was verified, medicines would generally be ordered as the pharmacy only held a small amount of stock. The medicines were then picked against the stock order using the prescription, they were assembled and then passed on for an accuracy check. They were labelled in accordance with requirements. Once the accuracy check had taken place items were packed by the same pharmacist completing the accuracy check. The other pharmacist completed the final check of the packing slip against the parcel prior to the parcel being dispatched.

Robust audit trails supported the prescription journey. An electronic audit trail clearly identified when the original prescription for a POM was received. The audit trail also identified when a pharmacist had verified a prescription. And a manual audit grid stamp identified who had completed the clinical check of the prescription, labelling and assembly, the accuracy check and the dispatch of the medicine. In addition to this the pharmacy used stickers to mark cold chain medicines and controlled drugs. To mitigate the risk of missing these medicines when couriers attended to collect packages, the pharmacy placed a white box marked with a specific cold chain or CD sticker onto the dispatch shelf. This prompted a team member to retrieve the assembled medicine from the fridge, freezer or CD cabinet.

The pharmacy's risk register and medicines risk assessment clearly identified and set out how risk associated with the delivery of medicines was managed. And the pharmacy's computer system linked to a platform which enabled the team to organise and where appropriate monitor deliveries. The pharmacy used robust packaging for its medicines and specialised wool packaging was used to send cold chain medicines. The pharmacy had evidence to show how it had worked with the manufacturer of the wool packaging to complete temperature tracking exercises. The team contacted people during hot weather to discuss suitable delivery arrangements for medicines if a heat wave was experienced.

The pharmacy used licensed wholesalers. Prior to entering into a service agreement with its main wholesaler all three team members visited the wholesaler. The visit had provided the team with the opportunity to assess whether the wholesaler was a good fit for the business. For example, it had considered how the wholesaler managed risks associated with the storage and shipping of medicines. The visit had also helped the team establish a good working relationship. The pharmacy did not generally keep POMs in stock. The exception was when part of an original pack was supplied. Where this was the case the supply was made in a white box and appropriately labelled. It kept small quantities of commonly used veterinary medicines and ordered the remainder of medicines for next day delivery. And it maintained audit trails of the medicines it received. The pharmacy advertised the turnaround time of prescriptions clearly on its website.

Medicines were stored in their original packaging in an organised manner. A date checking matrix was in place and the team completed date checking tasks regularly. Medicines close to their expiry date were segregated into a basket to support additional checks during the dispensing process. For example, length of the prescribed course of medicine. The pharmacy's fridges and freezer were a suitable size and temperature monitoring ensured medicines subject to cold chain requirements were kept at the correct temperature. The pharmacy had a CD cabinet and this was fitted securely.

The pharmacy had a waste management contract in place with a national company. It had appropriate medicine waste bins for the disposal of medicines. It received medicine alerts from its wholesalers and through VMD news bulletins. And information about what to do if pets suffered an adverse reaction to a medicine was clearly published on the pharmacy's website. Pharmacists could remember signing up to alerts for human medicines via the Medicines and Healthcare products Regulatory Agency but could not recall receiving an alert to date. A discussion took place about the need to stay informed of alerts relating to human medicines due to the POMs the pharmacy supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to provide its services. Pharmacy team members use this equipment appropriately and in a way which protects the privacy of people using its services.

Inspector's evidence

The pharmacy had some equipment for counting capsules and tablets if needed. Electrical equipment was free from wear and tear and maintained to an appropriate standard. A set of scales in the dispensary were solely used for the purpose of weighing parcels to ensure accurate postage rates were applied. Pharmacists had up-to-date reference resources. Most of these were online, such as the VMD's product Information Database. The pharmacy stored some records electronically and computers were password protected. The premises had no windows and there was no public access into the premises. This meant information displayed on computer monitors was safeguarded from unauthorised view.

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.