General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: www.your-chemist.com, Unit 3, Stratford Workshops, Burford Road, London, E15 2SP

Pharmacy reference: 9011418

Type of pharmacy: Internet / distance selling

Date of inspection: 10/12/2024

Pharmacy context

The pharmacy provides its services at a distance and people are not able to physically access the premises. It provides NHS dispensing services to a large number of people who live in care homes. And it supplies medicines in multi-compartment compliance packs to a few people who live in their own homes and need this support. This was the pharmacy's first inspection since it re-located to this premises.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. It protects people's personal information well. Team members understand their roles in protecting vulnerable people. And people can provide feedback about the pharmacy's services. The pharmacy keeps the records it needs to by law.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. And team members knew which activities should only be undertaken when there was a responsible pharmacist (RP) signed in. Team members explained that there were usually two pharmacists working each day and one would remain in the pharmacy if the other had to leave.

Medicines in similar packaging or with similar names were separated on shelves where possible to help minimise the chance of the wrong medicine being selected. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for rectifying them. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. The superintendent pharmacist (SI) explained that the team had spotted a trend of mistakes happening after lunch, so he had altered the team members' breaks and this change had helped reduce the number of mistakes being made. The SI said that the pharmacy was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He explained that an incident report would be completed for any dispensing errors, and a root cause analysis would be undertaken. The complaints procedure was available for team members to follow if needed and the pharmacy's complaints policy was available on the pharmacy's website. The SI said that the pharmacy had not received any recent complaints.

The pharmacy had current professional indemnity insurance. The correct RP notice was clearly displayed, and the RP record was completed correctly. The SI explained that the pharmacy's workload was planned in advance of people needing their medicines so emergency supplies were not needed. The private prescription records were largely completed correctly, but the correct prescriber details and appropriate date on the prescription were not routinely recorded. This could mean that the pharmacy may find it harder to find this information if needed in future. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was removed by a specialist waste contractor, computers were password protected and people could not see into the pharmacy from the street. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. The SI said that the pharmacy was in the process of requesting smartcards for newer team members.

Team members had completed training about protecting vulnerable people. And they knew to refer to the pharmacist if they had any concerns about a vulnerable person. The SI said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There were two pharmacists working at the pharmacy on the day of the inspection (one was the SI). There were two team members undertaking administrative duties. The SI explained that three members of the team had qualified and worked overseas as pharmacists. But they had not been enrolled on the GPhC Overseas Pharmacist Assessment Programme. Two had worked at the pharmacy for less than three months. And the SI explained that one had worked at the pharmacy for less than three months but had previously worked at the pharmacy on and off over the last two years. And one team member who was employed as an operation lead. Following the inspection, the SI provided confirmation that all team members undertaking dispensing tasks had since been enrolled on an accredited course for their role.

Holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The pharmacy was up to date with its dispensing. Team members worked well together during the inspection and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The SI said that team members were provided with some ongoing training. Team members underwent an induction, and this was recorded on a matrix. The induction programme included training on stock management, expiry-date checking, acute prescriptions, and SOPs. The pharmacists were aware of the continuing professional development requirement for professional revalidation. The SI explained that he had recently completed some training about sodium valproate and inhaler technique. He had also visited one of the care homes to carry out some training with the nurses on inhaler technique.

The pharmacists started work before the pharmacy's official opening times so that they could discuss and plan the workload for the day. The team then had a meeting to discuss any issues, prioritise workload and allocate tasks. The pharmacists felt able to make professional decisions. Team members felt comfortable about discussing any issues with the pharmacists. And they had informal ongoing performance reviews. No performance targets were set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured against unauthorised access. It was bright, clean, and generally tidy throughout. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities were available in the communal area of the building. There were separate hand washing facilities available.

There were several workstations and a separate checking area. There was an office separate to the dispensary. There was a small kitchenette area available in the pharmacy with hot and cold running water.

The pharmacy’s website indicated that the pharmacy made online sales of over-the-counter medicines. But the SI confirmed that this function had been disabled and the pharmacy did not sell medicines via its website. He said that he would speak with the website provider about this.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from licensed wholesalers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

The pharmacy's services, opening times and contact details were clearly advertised on its website. The pharmacy did not sell any medicines via its website. Workspace in the dispensary was largely free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels and backing sheets for multi-compartment compliance packs when they dispensed and checked each item to show who had completed these tasks.

The SI explained that the care homes were responsible for ensuring that people taking higher-risk medicines were having the relevant blood tests done at appropriate intervals. And the pharmacy would contact the care home if there were any queries about a person's prescription. Prescriptions for Schedule 3 and 4 CDs were not highlighted which could increase the chance of these medicines being supplied when the prescription was no longer valid. The SI explained that the validity of prescriptions was checked before the medicines were supplied. Dispensed fridge items were kept in clear plastic bags to aid identification. And these were kept separate from other medicines when being transported. The SI explained that the delivery driver handed over fridge and CDs separately to care home staff. And they ensured that the CDs were checked by the staff member and signed for. The SI said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy dispensed these medicines in their original packaging. The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. And he showed how the pharmacy kept a record of any action taken. This made it easier for the pharmacy to show what it had done in response. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and it was not overstocked.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly, and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. And items with a short expiry were highlighted. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept

separated from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Part-dispensed prescriptions were checked daily. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy provided the care homes and surgeries with a list of items owed to people. And informed them about any long-term supply issues. The SI explained that any potential supply issues were noted at the pharmacy when the prescriptions were initially screened. This allowed time for the prescriber to be contacted and any issues addressed. Prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacy supplied medicines in pouches to some people who needed this support. The pharmacy used a robot for this type of dispensing. Each pouch contained medicines to be taken at the same time as each other. A list of the medicines was printed on each pouch and the time of day the medicines were to be taken. The SI explained that the batch number and expiry date of the medicines was recorded on the system and was available if needed.

The SI explained that a medicines optimisation service (MOS) team managed prescriptions for some people. A list of medicines requested was received by the pharmacy and cross referenced against the prescriptions received. The medicines for these people were supplied in multi-compartment compliance packs. A suitability assessment was completed by the MOS team to identify which medicines were needed to be dispensed into the packs. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Sections within the packs were labelled with details about the medicines they contained including the quantity. A photo of the resident was printed on the inside of the cover and on the side of the pack. And photo of the medicine and medication descriptions were put on the packs to help people and their carers identify the medicines. Patient information leaflets were routinely supplied which meant people had up-to-date information about their medicines. Team members wore gloves when handling medicines that were placed in these packs.

Deliveries were made by a delivery driver and the pharmacy used an app to track deliveries. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. The delivery drivers could not access the app when they were not at work, and they could not see details about previous deliveries. This information was only available at the pharmacy. The SI showed how the pharmacy could track the delivery driver, and view signatures and times of delivery. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. The SI said that the delivery drivers knew only to hand over medicines to an approved responsible person at the care homes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The pharmacy has processes to maintain its equipment.

Inspector's evidence

Equipment for measuring liquids was available. A separate measure was used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The SI explained that the dispensing robot could be accessed remotely by an engineer. And if it could not be fixed remotely, an engineer would attend the pharmacy within 24-hours.

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.