General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemists, 121A Shady Lane, Great Barr, Birmingham, West Midlands, B44 9ET

Pharmacy reference: 9011436

Type of pharmacy: Internet / distance selling

Date of inspection: 16/09/2021

Pharmacy context

This is a distance selling pharmacy which is situated in a purpose designed industrial unit after moving from its previous location in September 2020. The pharmacy is not open to members of the public, so it delivers prescription medicines directly to patients. And it also acts as a 'hub' and dispenses medicines in multi-compartment compliance packs for collection or onward supply from other pharmacies within the same legal entity. Most medicines are supplied in multi-compartment compliance packs to help people take their medicines at the right time. This inspection took place during the COVID-19 pandemic and the pharmacy has been providing Covid-19 vaccinations since January 2021.

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

The pharmacy effectively identifies and manages the risks associated with its services to make sure people receive appropriate care. It is responsive to feedback from members of the public and it uses this to make improvements. Members of the pharmacy team follow written procedures to make sure they work safely. They are aware of their mistakes so that they can learn from them, and they make changes to stop the same sort of mistakes from happening again.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which generally covered the operational activities of the pharmacy and the services provided. The SOPs had been prepared by the superintendent (SI) and signature sheets were used to record staff training. Roles and responsibilities of pharmacy staff were highlighted within the SOPs. The SOPs were the generic company SOPs and had not been amended to reflect that members of the public did not visit the pharmacy in person and that services were provided at a distance. Additional SOPs had been created for some of the pharmacy specific services, such as, the hub and spoke model, the dispensing robot and the accuracy checking dispensing assistant.

The pharmacy manager had carried out risk assessments for the dispensing robot and for the hub and spoke model. These risk assessments were ongoing and regularly reviewed. Changes to the SOPs and working practices were made to reflect the risks identified in the assessment. For example, some medicines were not suitable to be dispensed by the robot, and some dosage schedules, such as alternate day dosage for levothyroxine.

The pharmacy had been operating at its current location since September 2020 and, whilst they used a dispensing robot at the previous location for dispensing multi-compartment compliance packs, the robot had been replaced and upgraded so that it could hold more stock and dispense more compliance packs per day. This had enabled the pharmacy to dispense prescriptions on behalf of other MW Phillips pharmacies to reduce their workload. There was an ‘onboarding’ process for moving the workload across and the SOP documented what part of the process the hub and spoke pharmacies were accountable for. Consent was obtained from the patient before the packs were dispensed at the pharmacy. The onboarding process had been amended based on feedback and experience, for example, the spoke pharmacy carried out an additional accuracy check of the packs for the first four weeks and the responsible pharmacist (RP) at the hub pharmacy remotely accessed the spoke pharmacy’s patient medication record (PMR) to carry out a clinical check of prescriptions that had been uploaded by the spoke pharmacy to ensure they were correct and complete. The hub and spoke gave feedback to each other so that they could improve their processes and use any issues as learning opportunities.

A near miss log was available and the dispenser involved was responsible for correcting their own error to ensure they learnt from the mistake. A newer member of the team explained that she was made aware of any mistakes that she had made and gave some examples of how she used this knowledge to try and not make the same mistake again. The pharmacy manager explained that whilst near misses

were always discussed, they may not always be recorded, this meant that patterns or trends may not be identified. He explained that the technology built into the robot, including QR codes and barcode scanning, meant that errors were minimised and many of the traditional human errors, for example, selecting look alike, sound alike medicines (LASA's), were identified through the checks in the system before they became a near miss or dispensing error.

The Covid-19 vaccination centre had been operating since January 2020 and the patient journey was demonstrated. A large area was available and there was additional space that was used when the centre was busier. There was a one-way system in operation and if different vaccinations were being administered, these could be done in two distinct areas to keep them separate. There was ample space for people to wait, socially distanced, before and after their vaccination. A council funded lateral flow test (LFT) was offered before the vaccination, and people were offered a box of NHS LFT's to take home when they left. There was a folder containing SOPs for the service, copies of the patient group direction (PGD) and national protocol and completed vaccinator competency assessments. Each of the vaccination pods had a computer with access to PharmOutcomes and records were made at the time of vaccination. The pharmacy was currently operating a walk-in service, as well as an appointment booking system, and had seen a small increase in walk-in vaccinations due to a deadline for carers taking the vaccine approaching. Staffing for the service was organised in advance and there was a pool of vaccinators and volunteers available. A daily huddle took place for the vaccination service to share information.

Members of the team were knowledgeable about their roles and discussed these during the inspection. Various roles and tasks were delegated to team members and they trained up 'experts' in certain key areas, for example, there were members of the team that had received additional training on how to perform more advanced checks of the robot and how to clean and maintain it.

Personal protective equipment (PPE) was available and was being worn by the pharmacy team. Coronavirus information was displayed throughout the premises. Pharmacy team members were asked to carry out lateral flow tests twice a week and the pharmacy acted as a lateral flow test (LFT) collection point and also offered a locally commissioned LFT service.

People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and would involve the SI if they could not reach a solution. The pharmacy had received feedback on Google Reviews for the Covid-19 vaccination centre and had used the reviews as constructive feedback to make changes to their systems. There was a feedback point within the vaccination centre so that people could give their feedback immediately.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was displayed in the dispensary and the RP log met requirements. Controlled drug (CD) registers were in order and a random balance check matched the balance recorded in the register. Delivery records were maintained, and the RP was considering whether or not to introduce obtaining signatures for home deliveries for non-controlled drug deliveries as there had been no incidents during the pandemic.

Confidential waste was stored separately from general waste and destroyed securely. The pharmacy team had their own NHS Smartcards and confirmed that passcodes were not shared. The NHS Data Security and Protection Toolkit submission was completed by head office. The RP had completed level three safeguarding training and the details of local safeguarding bodies were available. Everyone involved with the Covid-19 vaccination centre had been screened by the Disclosure and Barring Service

(DBS). No formal safeguarding referrals had needed to be made, however, the RP had concerns about a young adult being pressurised into receiving the Covid-19 vaccine against his will, so had provided information, and asked him to come back at a later date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so they always have enough cover to provide the services. The team members work well together in a supportive environment and they can raise concerns and make suggestions.

Inspector's evidence

The dispensary team comprised of the pharmacy manager (RP at the time of the inspection), four dispensing assistants, a trainee dispensing assistant and a pharmacy student. The pharmacy manager explained that he felt the staffing levels were comfortable and they were slightly overstaffed because onboarding had temporarily paused. The pharmacy team were losing approximately 1.75 full time equivalent dispensers in coming months, so recruitment had commenced to replace those hours. Onboarding was not planned to recommence until the new team members were trained in the pharmacy processes and knew how to operate the robot. The pharmacy shared a premises with the company head office so there were often other pharmacists on-site that could support, especially if the Covid-19 vaccination centre was busy. The company employed a number of delivery drivers that were based at the premises; they delivered to members of the public and they also delivered the compliance packs and stock to other MW Phillips pharmacies. Holidays were requested in advance using an online form and cover was either provided by other staff members as required, or they asked for support from another branches of MW Phillips.

Members of the team were enrolled on training courses. People that were new to the company often completed their induction period and dispensing assistant training at the pharmacy, before moving to a different pharmacy. The team had identified that accuracy checking took up a large part of the RP's time, especially since the increase in compliance packs, so had enrolled a dispensing assistant in an accuracy checking dispensing assistant course. This was intended to free up the RP to carry out other tasks. A monthly training plan had been designed so that the team undertook regular training. The pharmacy team had recently completed training modules for the latest NHS pharmacy quality scheme, in addition to the training on the training plan.

With the exception of the RP, the Covid-19 vaccination centre staff were a separate team to the dispensary team. This meant that the vaccination centre did not impact on the normal pharmacy workload. On the day of the inspection, the RP was acting as the supervising pharmacist for the service and obtaining consent for people using the service. He was being assisted by a dentist, who was helping to organise delivery of the service. The vaccinators were nurses and there were various volunteers also present.

The team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. There was a daily huddle within the dispensary to discuss any pharmacy issues, and to update on the progress of the planned workload for the week. The Covid-19 vaccination centre team also had a daily huddle. The pharmacy

staff said that they could raise any concerns or suggestions with the RP, SI or HR manager and explained that they were all responsive to feedback. The RP was observed speaking to every person that attended the Covid-19 vaccination centre to gain their consent and answer any questions that they may have. During busy times in the vaccination centre there was a second pharmacist available for the dispensary so the RP did not have to go back and forth. The pharmacy team had annual appraisals and the last ones had taken place in early 2021.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for the provision of healthcare services.

Inspector's evidence

The company's website www.mwphillips.co.uk was not working properly at the time of the inspection. The RP explained that an update to the content had not worked as intended and the website developers were working on a new website that was due to go live at the end of September. The holding page promoted the private travel service that the pharmacy offered. The RP had access to the test site and demonstrated how the website would look once it was live and explained that he was working through the content to ensure it was accurate. In the interim, the team had made sure that the pharmacy information on the NHS website, and Google, was accurate.

The pharmacy premises was situated in a large business unit and it was not generally open to the public. A portion of the premises was accessible to the public as it was being used for the Covid-19 vaccination centre. Any maintenance issues were reported to pharmacy manager or operations manager. The premises were smart in appearance and appeared to be well maintained. The temperature and lighting were adequately controlled. Staff had access to a communal kitchen area and WCs with wash hand basins. The premises were clean and tidy with no slip or trip hazards evident. Cleaning was undertaken by pharmacy staff and a cleaner. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap. Hand gel was readily available throughout the premises.

The dispensary was in a separate room within the premises and had controlled access. The dispensary was large with ample bench space. A dispensing robot was used for assembly of multi-compartment compliance packs.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services and supplies medicines safely. It gets its medicines from licensed suppliers and stores them securely and at the right temperature, so they are safe to use. The pharmacy team effectively dispenses prescriptions for other pharmacies within the same group so that they can focus on face-to-face services to members of the public.

Inspector's evidence

The pharmacy had an NHS distance selling contract, so members of the public did not access the pharmacy premises to collect prescriptions. People did visit the pharmacy for Covid-19 vaccinations and the service was clearly advertised outside the pharmacy. The entrance and route for people to follow within the premises was clearly marked. There was a large car park, the service was all on one level, there was ample seating available, and toilets were available for people using the service.

The pharmacy services could be accessed via the telephone and e-mail. A large percentage of the prescriptions were dispensed on behalf of other MW Phillips pharmacies and people contacted their usual pharmacy if they had a query about their prescription. Whilst the pharmacy services were available to people across the UK, there was very little demand from outside of the local area, so medicines were either delivered directly to people by the pharmacy's drivers or to other MW Phillips pharmacies for onward supply. A courier company was available to deliver prescriptions to people outside of the usual delivery areas.

Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. Audit sheets were used to record which members of the team had been involved in dispensing compliance packs for the spoke branches and a copy of this was supplied with their delivery. The RP was aware of the MHRA and GPhC alerts about valproate and had some counselling information available, although the SOPs had not been adapted to demonstrate how and when people would receive counselling. Various medicines audits had taken place for the NHS PQS.

The pharmacy had two different processes for multi-compartment compliance packs running in unison. One was for people that had their medicines supplied directly from the pharmacy, and the other was for the spoke pharmacies. People that had their medicines supplied directly from the pharmacy had prescriptions for any medicines that were dispensing into the packs ordered by the pharmacy, a dispensing assistant maintained records of the requests and chased up any missing items and queried any changes with the surgery. External items were ordered when the patient required them and they usually phoned the pharmacy when they required a repeat supply. The PMR system showed which prescriptions were acute and which were repeat, this helped the dispensing assistant to identify items such as antibiotics, which were required before the next supply of compliance packs. The compliance packs were assembled using the robot and then checked by the pharmacist.

The spoke pharmacy followed a slightly different process. They imputed the details of the prescriptions onto their computer system, they made any interventions and the pharmacist carried out a clinical

check. They then submitted a batch of prescriptions to the hub for dispensing. The hub then downloaded the information, printed labels for the packs and the robot dispensed the medication. An accuracy check then took place within the hub pharmacy before the completed packs were sent to the spoke pharmacy.

The stock for the robot was de-blistered and placed into canisters and each canister contained the same batch number and expiry date so that there were no mixed batches. Barcodes were used to manage the stock and the barcodes from the canister and the stock boxes were scanned before it was put into the robot as an accuracy check. A dispensing assistant kept additional records of when the stock had been removed from its original packaging and which members of the team had been involved in the process. A pharmacist or experienced member of the team performed a second check before the canisters were authorised to be loaded into the robot.

The computer system that accompanied the robot had photographs medication and, if they were available, printed them onto the labels attached to the packs so that people could differentiate between the different medicines in there. In the event that the computer system did not have a photograph of the medicine, the dispensing assistant added a description of the medication for the label. The computer system used QR and barcode technology as an additional accuracy check throughout the process. Each of the compliance packs had a barcode assigned to it which was scanned throughout the dispensing process.

The pharmacy team did not undertake suitability risk assessments when considering whether to accept a request for dispensing into a compliance pack, so it could not always show why it supplied these or that other options had been considered. A sample of dispensed compliance packs were seen to have been labelled with descriptions or photographs of medication. Patient information leaflets were not routinely supplied. Supplying patient information leaflets is a legal requirement.

Prescriptions were suppled to a few local care homes and they were supplied in original packs. Each pack had a dispensing label and a QR code attached. The QR code was scanned at the care home as a patient safety check and it was linked to an electronic medication administration record.

There was a separate area within the dispensary for the preparation of the Covid-19 vaccination and it was stored in a medical fridge. This fridge was only used to store the vaccine. As the pharmacy premises was large, there was plenty of storage for the clinical waste generated by the vaccination centre.

Date checking took place regularly and no out of date medication was seen during the inspection. There was a date checking matrix used to record date checking. The medicines placed into the robot were used quickly, however, the robot did track expiry dates and had the ability to alert the team if there were any short dated batches in the canisters. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging, until they were de-blistered for the robot. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Medicines were obtained from a range of licenced wholesalers and the pharmacy was alerted to drug recalls via emails from the MHRA.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were usually working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. The equipment is serviced regularly and there is a contingency plan in place in case the equipment fails.

Inspector's evidence

The pharmacy had access to a range of reference sources, including the BNF and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Counting triangles were used and there was a separate, marked triangle used for cytotoxic medicines. Computer Screens were not visible to the public as they were excluded from the dispensary.

A dispensing robot was used to assemble multi-compartment compliance packs and the team members that used the robot had received training on how to use it. The robot was serviced monthly, and some staff members had been trained to undertake cleaning and minor maintenance. The team had telephone numbers for the UK based technicians, and specialists in Canada were contacted if the UK technicians could not resolve a problem. There was a webcam available so that the technicians could be shown error messages or ask to see certain parts of the robot. The team could resort to manual dispensing if technical problems with the robot could not be resolved.

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.