General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Echo, 17 Wadsworth Road, Perivale, Greenford, UB6 7JD

**Pharmacy reference:** 9011437

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 02/11/2020

## Pharmacy context

This is an internet pharmacy. It is situated in a large industrial unit and is closed to the public. It is owned by the same parent company as Lloyds pharmacy Ltd. and operates its services through an online 'app'. People use the app to request their prescriptions. The pharmacy then orders and dispenses them. And it delivers them to people across the UK. The inspection was conducted during the COVID-19 pandemic.

## 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 identifies its risks well. And its team members have adapted their working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. Team members record their errors and review them to identify the cause so that changes can be made to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy has insurance to cover its services. Team members know how to protect people's private information and know how to protect the safety of vulnerable people. And they respond well to feedback.

### Inspector's evidence

The most recent figures showed that the number of cases of COVID-19 in the area was higher than the national average for England for the previous week. To help reduce the risk of spreading coronavirus, the pharmacy had reviewed its working practices to reduce risk for its team members and the public. Team members generally wore masks. And some wore disposable gloves, or they sanitised their hands regularly. Staff were expected to sanitise their hands when entering and leaving the building, when entering and leaving the staff area and when entering and leaving the dispensary. The pharmacy had introduced a one-way system around its spacious dispensary. But team members were occasionally seen to take short-cuts, moving against the one-way system.

The pharmacy operated a large-scale dispensing service, supplying prescriptions all over the UK. Its prescription volumes had increased significantly since it became operational in 2016. The business had recently been acquired by the owner of the Lloyds pharmacy chain and had moved part of its operation into new larger premises approximately two months earlier. And was temporarily operating a 'hub and spoke' model. With these premises functioning as the dispensing 'hub'. The inspector and superintendent (SI) discussed the importance of having contingency plans in place to ensure that the pharmacy would be able to maintain its services in the event of closure due to the COVID-19 pandemic. The SI was reminded of the requirement to report any COVID-19 infections, believed to have been contracted at work, to the relevant authorities.

The pharmacy had procedures for managing risks in the dispensing process. Team members discussed every incident, including their near miss mistakes, as soon as they were discovered. And they recorded them electronically. They also discussed them within the larger team during the daily briefing meetings. The pharmacy held team briefing meetings with every change of shift. Any errors led to an email communication to each team member and a staff forum, led by the pharmacy's clinical manager. The team discussed its mistakes to help prevent the same or similar, mistakes from happening again. The inspector, SI and responsible pharmacist (RP) discussed the importance of recording what the team had learned from its near misses and any actions arising from them. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help prevent similar mistakes in future. Team members reviewed and reflected on their mistakes every month to learn and improve.

The team worked under the supervision of the RP. The RP's notice had been placed on display for the team to see. The pharmacy had a set of up-to-date standard operating procedures (SOPs) for team members to follow. The pharmacy team sought customer feedback through its website and general conversations with people. And the team had responded positively to previous concerns by upskilling

the training requirements for members of its customer services team and appointing a clinical pharmacist. Comments on the pharmacy's website generally demonstrated a high level of customer satisfaction overall. But the team had also received complaints from people during the early stages of the pandemic when the team were at their busiest. Complaints arose from people's prescriptions not being ready when they expected them to be or when the team were unable to supply all of their medication at the same time. But although both of these issues were largely out with the direct control of team members, they had consulted people's GPs for alternatives or divided supplies into smaller batches to ensure that people did not run out of their medicines.

The pharmacy had a complaints procedure which corresponded with NHS guidelines. And it had a SOP for staff to refer to. But customer concerns were generally dealt with at the time by the customer services team, clinical manager or RP. Staff could provide details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. Insurance arrangements were in place until 07 October 2021 when they would be renewed for the following year. The pharmacy kept its records in the way it was meant to. The RP recognised the importance of maintaining the pharmacy's essential records so that they were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. Confidential waste was set aside for collection and subsequent disposal by a licensed waste contractor. The pharmacy stored its completed prescriptions securely in the dispensary. Team members had completed appropriate safeguarding training. The RP could access details for the relevant safeguarding authorities online. Staff had not had any specific safeguarding concerns to report.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

In general, the pharmacy team manages the workload safely and effectively. Team members work well together. And they have opportunities to provide feedback to one another, so that they can maintain the quality of the pharmacy's services. But not all team members have completed the appropriate training.

### Inspector's evidence

The pharmacy operated its services using two separate teams working a morning or afternoon shift Monday to Friday. The team on duty during the inspection consisted of 12 pharmacists and 12 dispensers (including four trainees). The team also employed 16 ‘pickers’ and 13 ‘dispatchers’ many of which were agency staff. ‘Pickers’ and ‘dispatchers’ used sophisticated bar code scanning systems to store items, select them and dispatch them after they had been dispensed and checked. But they had received basic in-house pharmacy training only. And none of these team members had been trained according to an accredited training course. The SI and inspector discussed the importance of recognising what activities constitute dispensing and agreed that staff should be trained in accordance with the GPhC’s latest guidance on training of pharmacy support staff. The team on duty on each shift was subdivided into a number of sub teams, working at their own area of dispensing bench. Pharmacists moved around between these sub teams to accuracy check prescriptions when ready.

The Pharmacy had conducted an individual risk assessment for each of its team members. And this was reviewed regularly. Adjustments had been made in some cases where individuals had been provided with the tools to allow them to work safely and securely from home. Staff were asked to complete a questionnaire each time they arrived for work to ensure that they did not enter the workplace if they had any signs or symptoms of having COVID-19 or had been in contact with anyone else who had. And they were also required to scan a QR code to track the time at which they entered the building.

In general staff were able to raise queries and concerns. And they were invited to contribute to team briefings to express any concerns or contribute any ideas they may have. The inspector, SI and RP, discussed the importance of listening to staff concerns and ensuring that team members understood that any targets set around the numbers of prescriptions dispensed and checked were not in contradiction with general staff welfare or professional decision making and the safe delivery of services.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are sufficiently clean and secure. The pharmacy has made adequate adjustments to help keep people safe during the pandemic. But the adjustments made are not all being used as effectively as they could be. This means there are further opportunities to ensure that team members and people using its services, are protected.

### Inspector's evidence

The pharmacy was situated inside a large warehouse on an industrial estate. It had moved its dispensing and supply service to these premises recently after its other premises proved inadequate for its increasing workload. It had a staff entrance at the side of the building with an electronic card entry system for team members. Staff exited the building using a different set of doors to the ones used to enter it. Inside the building the pharmacy had set up a one-way system with a route from the entrance into the staff canteen area, or to the offices on the mezzanine floor above. Staff entered the large warehouse dispensary from the staff area through one set of doors. And exited it back into the staff area from another set of doors. Both sets of doors were approximately two metres apart. The pharmacy had a separate set of doors for deliveries of stock. And it had laid out a one-way system around the warehouse by placing stickers on the floor to show the direction of travel. But the warehouse was large, and the one-way system meant that team members had to occasionally take a longer route to where they wanted to get to. So, some were observed ignoring the direction of travel. Others were also observed making physical contact with one another rather than trying to maintain an adequate distance between one another.

The pharmacy had organised its workflow into several smaller teams. Each team generally had its own area of dispensing bench and team members had their own workstations in different areas of the pharmacy. And for the most part, they were able to keep more than one metre apart from one another. But at busy times it was difficult to maintain social distancing within these smaller teams. So, the pharmacy was missing opportunities to use its spaciousness to maintain an appropriate distance between team member. And to further protect them from the spread of the virus. The pharmacy was fitted out with dispensing benches, open shelving and drawers. It had a sink for washing equipment and making up liquid preparations. It was generally clean, tidy and organised.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides its services safely. And makes them easily accessible for people. Staff understand the actions to take if any medicines or devices are not safe to use to protect people's health and wellbeing. The pharmacy team gets its medicines and medical devices from appropriate sources. And it stores them properly. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing.

### Inspector's evidence

The pharmacy's services focused on ordering people's repeat prescriptions, dispensing them and posting them using the royal mail track and trace service. But with the expansion of its business the pharmacy team was organising a new delivery process and was introducing a collection service from Lloyds pharmacies. The pharmacy promoted its services on its website and through its app. The app provided a facility for people to track their prescriptions, raise queries and chat to staff. And it also prompted people to re-order their prescriptions when they were due, to help prevent them from running out. The pharmacy had applied for a relocation pf premises earlier in the year. And registration had been granted by the GPhC. But due to unforeseen delays an NHS contract would not be available to the pharmacy until the summer of next year (2021). So, in the meantime, app services were managed from the original branch in Acton. Pharmacists at the Acton branch were also responsible for clinically checking prescriptions. Prescriptions were then dispensed and checked from the new premises in Perivale. And returned to Acton where they were collected the same day by Royal mail for delivery. The SI and inspector agreed that it was important to check that this business model was compliant with the pharmacy's NHS terms of service. The vast majority of prescriptions were obtained electronically. And could be viewed at both premises through the pharmacy's web-based patient medication record system (PMR). The system also had a facility for pharmacists to communicate with one another. Those performing the clinical check provided the checking pharmacists with information about their decision making on an individual PMR. And the supplying pharmacy could ask questions in return. Communications between teams appeared as easy to see speech bubbles on the PMR.

Pharmacists used the app to provide people with advice about their medicines and answer any queries they may have. This also allowed pharmacists to provide people on high risk medicines with additional advice. The team could also use the app to identify when people may be over or under ordering their medicines. And to see when people's medicines may be getting out of sync. The pharmacy had SOPs for staff to follow. SOPs were under continual review as the business expanded and the size of the team grew. Agency staff had been briefed on their tasks but not all agency staff had read the SOPs. The inspector and superintendent discussed the importance of ensuring that all staff adhered to safe processes. They agreed that regardless of how automated the packaging and dispatch process was, it was vital that staff cross checked the person's name on the medicine with the name on the prescription. And that the name and address on the postage label was also correct.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately and in their original containers. And stock on the shelves was tidy and organised to assist selection of the correct item. The pharmacy team date-checked the pharmacy's stocks regularly, checking a different section each time. And it identified and highlighted any short-dated stock. A random sample of stock checked by the inspector was in date.

Team members kept records to help them manage the process and to show what had been checked, when and by whom. And they put any out-of-date and patient returned medicines into dedicated waste containers. The team stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures daily to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts and kept appropriate records.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. It had equipment for counting tablets and capsules. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of face masks and gloves, which were appropriate for use in pharmacies. Team members washed or sanitised their hands at regular intervals throughout the day and on entering and leaving different areas of the building.

The pharmacy's computers were located at different workstations the dispensary, in a way that meant that staff members using them were not close to one another. Computers were password protected and members of the public didn't access the building. Team members generally used their own smart cards when working on PMRs, so that they could maintain an accurate audit trail and ensure that access to patient records was appropriate and secure.

## 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. |