General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Doctors Dispensing Services Ltd, 3 Young Place, Kelvin Industrial Estate, East Kilbride, Glasgow, South Lanarkshire, G75 0TD

Pharmacy reference: 9011489

Type of pharmacy: Internet / distance selling

Date of inspection: 15/08/2024

Pharmacy context

This is a distance selling pharmacy set within a separate wholesaler premises in the town of East Kilbride. The pharmacy's only service is dispensing prescriptions for long-term conditions which it sends to people living in the United States. The pharmacy receives prescriptions from a UK prescriber and works with an international prescription service provider based in Canada. The superintendent pharmacist is the only employee of the pharmacy. People do not visit the pharmacy in person and medicines are sent by post.

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 does not identify and manage all the risks for the provision of medicines at a distance. And it does not have documented risk assessments to ensure dispensing is safe and effective.
		1.2	Standard not met	The pharmacy does not sufficiently review the safety and quality of its service. It does not suitably audit its dispensing to ensure it makes appropriate supplies.
		1.6	Standard not met	The pharmacy does not always record details of issued private prescriptions within required timeframes and therefore records are not accurately maintained as required.
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 suitably identify all the risks associated with providing services at a distance. And it does not complete audits to ensure that it's service continues to be delivered safely. The pharmacy does not always complete records of supplies of medicines made against private prescriptions in a timely manner as required by law. The pharmacist records details of mistakes made during the dispensing process and takes steps to help prevent the same mistake occurring. The pharmacist knows to keep people's private information secure and has undertaken training for protecting vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which had been written by the superintendent (SI) pharmacist. These were prepared by the SI in February 2023 and were due to be reviewed in February 2025. They included SOPs about the responsible pharmacist (RP), medicine storage, prescription labelling, pharmacist assessment and intervention and prescription dispatch. The pharmacy had been issued with further SOPs by the Canadian prescription service provider which required additional steps in the dispensing process, such as annotating medicine boxes with stickers alerting people that their medication may look different or have a different name. The SI did not have any documented risk assessments for providing services at a distance. For example, the risks associated with dispensing medicines with different UK and US licensed indications or risks associated with the differences between US and local prescribing and treatment guidelines.

The SI recorded mistakes made during the dispensing process known as near misses. And they completed a quarterly review of the near misses. Records showed near misses had been recorded in August, and before this the last recording was in March. The SI explained that it was possible not all near misses made had been recorded, and this had been identified as an improvement to be made in the most recent quarterly review. The most recent mistakes recorded involved an incorrect dosage printed on dispensing labels and an incorrect quantity dispensed. And they had documented the actions taken to rectify the error. The pharmacy recorded details of errors that were identified after a person had received their medicines, known as dispensing errors. The details of the error were recorded, and action taken. The SI explained they were informed of any dispensing errors by the Canadian prescription service provider. And the last dispensing error had occurred in June 2021 and involved a person receiving medication for another similarly named person. The SI had identified learning from this incident to be more vigilant double-checking names and addresses of people. The SI was involved in each step of the dispensing process, which included labelling, dispensing and checking. They took a break between dispensing the medicines and checking them to help prevent errors. Audits to help inform risk assessments and ensure ongoing improvements in the safety and quality of the service provided were not routinely completed. The SI provided an example of one audit which was completed in July 2020. This audit included information about the service provided, a determination on the current staffing levels in relation to workload, and an explanation of the process for receiving a prescription via the Canadian prescription service provider.

The SI displayed a RP notice within the pharmacy, and this reflected the correct details of the RP on duty. The SI explained that people using the pharmacy did not routinely contact the pharmacy directly. Any complaints or feedback were reported by people to the Canadian prescription service provider,

who informed the pharmacy. The SI explained the only complaints or feedback given were in relation to dispensing errors made and this did not happen often. The SI would liaise with the Canadian prescription service provider to resolve any complaints.

The pharmacy had current professional indemnity insurance and the SI confirmed the insurers were aware of all aspects of the service delivery which included sending medication abroad. The pharmacy's RP record was completed correctly. It kept a record of private prescriptions dispensed in an electronic spreadsheet. The records were complete and included the date on the prescription and the supply date. There were two large bundles of private prescriptions waiting to be recorded in the register from April 2024 onwards. This meant that the pharmacy did not maintain accurate, timely records of private prescriptions following supply. This did not meet legal requirements and may make it difficult for the pharmacist to find details of the original prescription in response to any queries or errors.

The SI had completed training about the General Data Protection Regulation. The pharmacy used the Royal Mail website to print address labels for people's parcels and access was password protected. Confidential information was shredded on site. The SI had completed training for safeguarding vulnerable adults and children. They had not experienced safeguarding issues within their role as they didn't have contact with people using the services. They were registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's current workload is suitably managed by the superintendent pharmacist. They feel comfortable to raise concerns with the owner as necessary. And they ensure they complete professional development as required.

Inspector's evidence

The only team member who worked within the pharmacy was the SI, who was also the RP. They completed all tasks involved in the dispensing process, including labelling prescriptions, dispensing the medications, completing final clinical and accuracy checks, and preparing the medication for postage. The SI felt there was only enough workload for one person and monitored prescription numbers. They explained if they felt it was necessary to employ additional team members, this could be raised with the owner. They felt able to raise concerns with the owner and although there were no formal appraisals or performance reviews completed, the SI had informal discussions with the owner regularly. For periods of absence including annual leave, the pharmacy did not open. The Canadian prescription service provider was informed and prescriptions were sent to other pharmacies associated with them. The pharmacy was not set any targets by the owner. The SI had been trained in the role by the previous pharmacist. And they kept their professional knowledge up to date by completing continuing professional development which included peer reviews with the owner.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided.

Inspector's evidence

The pharmacy was set within a larger separate wholesaler warehouse. The pharmacy was situated up a flight of stairs and access was restricted to the SI, owner and the manager of the wholesaler. The pharmacy was spacious and had different bench spaces to complete the different aspects of the dispensing, checking and packing processes. The pharmacy was cleaned by a cleaner once a week while the SI was present. The pharmacy had two computers, one of which was used for the patient medication record system and the other for all other tasks, including administration tasks.

The warehouse had toilet facilities that provided hot and cold water for handwashing. The temperature in the pharmacy was comfortable. Lighting was bright where dispensing and checking was done but there were some broken lights near the computers. The SI confirmed this had been reported to maintenance and was in the process of being fixed.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its service well. It ensures medicines are securely and discreetly packaged for posting. And it provides tracking details for people, so they are aware when their deliveries are due. The pharmacy completes checks on medicines to ensure they remain fit for supply. And it responds appropriately to notifications about the safety of medicines.

Inspector's evidence

The main warehouse had level access from a car park. People did not attend the pharmacy to collect their medication in person, as all medicines were shipped via Royal Mail. The pharmacy did not routinely have direct contact with people who received their medication. The pharmacy's details were provided on the dispensing labels and via the Canadian prescription service provider if necessary. The pharmacy provided tracking information to people via the Canadian prescription service provider, so they knew when their deliveries were due. Any failed medication deliveries were returned to the pharmacy by the US Postal Service who indicated on the parcel the reason for the failed delivery. And the pharmacist informed the Canadian prescription service for resolution. People's main point of contact for any queries related to their medication was the Canadian prescription service provider. For people who had repeat supplies authorised on their prescriptions, contact was made by the Canadian prescription service provider approximately four weeks ahead of medicines being required. And checks were made if there were any changes to their health or medication. This allowed the pharmacy time to dispense and post the medication. The person's US doctor was responsible for monitoring of chronic conditions and any changes to the medication were communicated to the pharmacy and UK-based doctor via the Canadian prescription service provider. People had their first supplies of medication dispensed locally in the US before being eligible to have their medication dispensed by the UK based pharmacy. This helped ensure people were monitored locally and the treatment was safe and effective before it was supplied long-term.

The SI used baskets to keep prescriptions and medicines together to help prevent the risk of them becoming mixed up. They signed "dispensed by" and "checked by" labels on prescription medications as an audit trail. As the SI was the only employee, signatures were not required to identify who was involved in which stage of the dispensing process but remained part of the process. The pharmacy received the UK private prescription and had access to a copy of the US prescription and some medical history for the person. The UK-based doctor was employed by the same company as the pharmacy and worked remotely. The SI completed and recorded monthly checks of the doctor's registration status with the General Medical Council to ensure there were no restrictions on their practice. They did not know if the UK based prescriber was required to be registered with the regulator for indpendent medical agencies. The SI confirmed that prescriptions were signed digitally by the GP and information pertaining to the electronic signature, including when the prescription was signed and the IP address of where it was signed could be tracked by the Canadian prescription service provider. For people who had repeat supplies authorised on their prescriptions, the Canadian prescription service provider supplied the pharmacy a copy of the original prescription which included the details required for the pharmacist to dispense from. And it included the date the UK-based prescriber had signed the original prescription. The pharmacist did not refer to the original prescription when issuing the repeat supplies. The SI generally stored original prescriptions by the month they were issued so the original prescription could be retrieved if necessary. However, there was a large volume of prescriptions waiting

to be recorded in the private prescription register and filed from April 2024. People submitted a profile to the Canadian prescription service provider which included their medications, medical history, photographic identification and drug allergies. This information was shared with the pharmacy so the pharmacist could refer to it, but the pharmacist did not routinely check the profiles.

The pharmacy had an owings procedure for when it could not supply the full quantity prescribed. The pharmacy would order what was required and usually received the medicines within a few days. It did not send part-dispensed prescriptions with owed medicine to people. If the full quantity requested on the prescription could not be supplied, the prescription was returned to the Canadian prescription service provider to find an alternative pharmacy who could provide the full quantity for the person.

The SI packaged medicines into plain cardboard boxes for shipping. Labels for shipping were printed and attached to plain postage bags. The labels were marked for customs to show they contained medication but did not specify which medication it was. The packages were sealed into a Royal Mail bag which was left for uplift in a manned department of the wholesalers, which was covered by CCTV. The pharmacy provided people with the invoice, a copy of their US prescription and patient information leaflets which were supplied to the pharmacy by the Canadian prescription service provider. These patient information leaflets were in addition to the patient information leaflets that were included in the original manufacturers packaging. This was to ensure that people had the necessary information to take their medicines effectively.

The SI completed a monthly stock count and checked the expiry dates of medicines. Medicines that were going out of date in the next six months were quarantined and were not used. The pharmacy received alerts about medicines from the Medicines Healthcare Regulatory Agency. These were printed, actioned and retained. The pharmacy had never received any reports of adverse reactions to medicines. The SI explained these would be relayed by the Canadian prescription service provider. The SI knew the process for reporting adverse reactions through the Yellow Care scheme if necessary. The SI explained that the American Food and Drug Administration (FDA) sometimes opened the posted medication to complete checks at international custom control and then returned the opened parcels to the pharmacy. The SI ensured that the person was informed of this through the Canadian prescription service provider, and a new prescription was generated. Returned medicines were disposed of in yellow bins in the wholesaler's warehouse, but the SI was not aware of how these were stored within the warehouse and whether or not the bins were sealed after the medicines had been added.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and reference resources it needs to provide its service. The pharmacist uses the equipment in a way which protects people's private information.

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF). It did not prepare liquid medicines or provide any medicines that were required to be broken down from larger containers or bottles. The only equipment the pharmacy used was a scale that was used to weigh the completed parcel, which was a requirement for posting them with the courier. The pharmacy stored confidential information on password-protected computer systems. The dispensary could not be seen by those in the warehouse due to its elevated position.

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.