General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rx Health Pharmacy, Unit 22, Richmond Industrial Estate, Richmond Street, Accrington, BB5 0RJ

Pharmacy reference: 9011519

Type of pharmacy: Internet / distance selling

Date of inspection: 04/02/2022

Pharmacy context

This is a distance selling community pharmacy in an industrial estate in the town of Accrington, Lancashire. It dispenses NHS and private prescriptions and sells some healthcare related products through its website. People do not access the pharmacy premises for services, so the pharmacy delivers medicines to people to their homes. It supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The inspection was completed during the COVID-19 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	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 has written procedures to help team members manage the risks associated with the services the pharmacy provides to people. The pharmacists act appropriately when mistakes happen to reduce the risk of similar mistakes happening again. They have a good understanding of their role in helping safeguard vulnerable people. The pharmacy suitably protects people's private information. It usually keeps the required records. But it has regular gaps in some of its records which means the pharmacy does not always meet its legal requirements.

Inspector's evidence

This was a small distance selling pharmacy that was run by a team of two pharmacists. The pharmacy had introduced several ways to keep the team and people who used the pharmacy safe from infection during the COVID-19 pandemic. It had separate checking and dispensing stations which helped the pharmacists socially distance from each other while they worked. There was hand sanitiser to use in the dispensary. People weren't asked to sign for the medicines deliveries they received from the pharmacy. This helped prevent spreading infection, for example though the sharing of pens between people and the delivery driver.

The pharmacy had a set of written standard operating procedures (SOPs) which were well organised with an index to help find a specific SOP. The superintendent pharmacist (SI) had reviewed and signed off each SOP. There were SOPs on various processes such as dispensing and the management of controlled drugs (CDs). During the inspection, the responsible pharmacist (RP) was seen to be working in accordance with the SOPs for dispensing. The pharmacy had scheduled to review the SOPs each year to make sure the pharmacy's current ways of working were up to date. Both pharmacists had read and signed the SOPs.

The pharmacy had a process in place to record and report near miss errors made during dispensing. For example, if the wrong quantity or the wrong strength of the medicine was dispensed. If an error was spotted by the pharmacist completing the final check, they informed the other pharmacist and asked them to rectify the mistake. Once the pharmacist had rectified the mistake, they made a record of the error on an electronic near miss error reporting system. The pharmacy had a QR code affixed to a dispensary bench. When the pharmacist scanned the QR code using a smartphone, they accessed the system, and completed the reporting form. The pharmacists recorded the date and time the error happened, as well as the nature of the error. At the end of the month, they created a monthly summary report. The summary report detailed any patterns in errors, and this helped the pharmacists decide if they needed to make any specific changes to the way they worked. For example, in one month, there had been a disproportionate number of errors involving lorazepam and loprazolam. To help prevent similar errors happening again, the pharmacists decided to affix a warning note next to where the medicines were stored. The note reminded the pharmacists to take additional care when dispensing these medicines. The pharmacy used the same online reporting system to record details of any dispensing errors that had reached people. The pharmacy advertised its complaints procedure on its website. People could either email or telephone the pharmacy to explain their concerns.

The pharmacy displayed a valid indemnity insurance certificate. An RP notice clearly displayed the name and registration number of the RP on duty. The pharmacy kept a RP record, but it was not complete.

There had been no records kept between 6 December 2021 and the day of the inspection. The RP signed in during the inspection. This was not in line with legal requirements. The inspector reminded the responsible pharmacist of the importance of keeping an up-to-date RP record and the RP gave assurances records would be completed each day. The pharmacy kept registers for controlled drugs (CDs), and they met legal requirements. Every two to three weeks, the team checked the balances in the registers against the pharmacy's stock to make sure they matched. During the inspection, a randomly selected CD was balance checked. The balance was correct. The pharmacy kept records of CDs that were destroyed after people had returned them. The pharmacy occasionally dispensed private prescriptions and kept an electronic record of supplies.

The pharmacy had procedures in place to protect people's personal information. It had an information governance folder which contained various policies such as data protection and confidentiality agreements. Both pharmacists had signed these. The pharmacy kept confidential waste in a separate bin to avoid a mix up with general waste. The team destroyed the confidential waste using a shredder. Both pharmacists had completed Level 2 training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). And the pharmacy had a written procedure for team members to follow if they had a safeguarding concern to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team and its team members have the skills and knowledge to safely provide the pharmacy's services. They manage their workload well and support each other as they work.

Inspector's evidence

Both pharmacists were working together on the day of the inspection. During the inspection, one of the pharmacists was not present in the pharmacy as they were delivering medicines to people's homes. The pharmacists supported each other in completing various tasks and managing their workload well. The dispensary benches were clear and well organised. During the inspection, the RP was able to dispense medicines at a steady pace. This was mainly because the pharmacy premises were closed to the public. The RP had reviewed the staffing profile and had plans to employ a full-time dispenser if the pharmacy continued to increase the number of prescriptions it was dispensing. The pharmacists managed the home delivery service themselves.

The pharmacists regularly attended pharmacy-related conferences to contribute towards their continuing professional development. This helped them refresh and update their knowledge and skills.

The pharmacists discussed workload planning and business growth while they worked. They also discussed the near miss error reports each month. They discussed their mistakes with each other. This helped create a culture of openness and honesty and so they could learn from each other’s mistakes and improve the way they worked. The RP explained he would raise any professional concerns with the local pharmaceutical committee or the GPhC.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure and are suitable for the services the pharmacy provides for people. The team works well to keep tidy the areas where it dispenses medicines.

Inspector's evidence

The pharmacy premises were well maintained and of a suitable size for the volume of services the pharmacy offered. The premises were kept clean and tidy. The main dispensary area was large and open plan. There were several work benches for the pharmacists to use to manage the dispensing process. The benches were kept tidy throughout the inspection. Medicines were tidily stored on shelves. There were toilet facilities with hot water for handwashing. Lighting was bright throughout the premises.

People accessed some services and information through the pharmacy's website. It had the name, physical address and GPhC registration number of the pharmacy displayed on the website and the registration status of the pharmacy could be found by following the link from the premises number logo. The website displayed the name and registration number of the superintendent pharmacist on the home page.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a basic range of services that suitably support people's health needs. The pharmacy appropriately manages and delivers its services. It obtains its medicines from reputable sources. And it generally stores and manages them as it should.

Inspector's evidence

The pharmacy advertised its services through its website www.rxhealthpharmacy.co.uk. And people contacted the pharmacy using the details on the 'about us' page on its website, or via telephone. The pharmacy website outlined the pharmacy's opening hours. The website had a section displaying general information on many medicines and health care conditions. The pharmacy advertised some general sales list medicines through its website. The website was managed by an external contractor and a third-party pharmacy supplied the medicines were supplied. The website detailed this arrangement, so people knew where there mediciens were supplied from.

The pharmacy provided large-print labels on request to help people with a sight impairment. Both pharmacists were fluent in various South-Asian languages such as Bengali and Urdu. Many people in the local community only spoke Bengali or Urdu and so the pharmacists were able to suitably communicate with them to help with their healthcare needs. The pharmacy's website incorrectly displayed flu vaccinations as a service the pharmacy offered. The RP gave assurances that these errors would be rectified after the inspection.

Once the pharmacists had dispensed, checked, and placed the medicines into bags, they stored them on shelves in the dispensary. The pharmacists used various stickers and put notes on the bags to use as an alert before they took them for delivery. For example, to highlight if a fridge line or a CD needed delivering at the same time. The pharmacists used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. They used separate benches to carry out the dispensing process and final checks of prescriptions. The pharmacists had a process of making sure that one pharmacist dispensed the medicines, and the other completed the final check. This helped reduce the risk of errors being made. They generally signed the dispensing labels to keep an audit of which pharmacist had dispensed the medicines and which pharmacist had completed the final check. But some sealed bags of medicines that were ready to be delivered to people, contained medicines that only had one signature on the dispensing labels. This meant that a full audit trail was not in place. The pharmacy provided owing slips to people on occasions when it could not deliver the full quantity prescribed. One slip was delivered with the medicine to the person and one was kept with the original prescription in the pharmacy for reference. This was used when dispensing and checking the remaining quantity. Once the remaining quantity had been dispensed, it was delivered to the person.

The pharmacy offered a repeat prescription ordering service. A pharmacist telephoned people to either request their repeat prescription orders on their behalf or remind them to place an order themselves. People were contacted around a week before their medicines were due to run out. The pharmacy kept a record of which medicines people had ordered. The records were checked against the prescriptions to make sure they were accurate. The RP was aware of the need to contact people via telephone to give people more information about their medicines if they were prescribed medicines that were high risk or required ongoing monitoring. The pharmacists asked people who were dispensed warfarin for their INR

records, and these were recorded on the pharmacy's electronic patient record where appropriate. The RP showed his understanding of the pregnancy prevention programme for people who were prescribed valproate. The RP was confident to ask people to make sure they knew to use appropriate contraception.

Some of the prescriptions the pharmacy received were for people who benefitted having their medicines dispensed in a multi-compartment compliance pack. People received their packs either weekly or monthly depending on their personal needs. When the pharmacy received the prescriptions, they were checked against master sheets to make sure they were correct. The master sheets detailed which medicines went in the packs and at what time of the day they were to be taken. For example, in the morning or at bedtime. The pharmacists supplied patient information leaflets with the packs.

The pharmacy obtained medication from several reputable sources. Every three months, the pharmacists checked expiry dates of the pharmacy's medicines. They highlighted short-dated medicines on the shelves. They kept a record of which medicines were short-dated and when they were due to expire. The inspector didn't find any out-of-date medicines after a check of around 20 randomly selected medicines. The pharmacy received notifications of drug alerts and recalls. And kept a record of the action taken. So, an audit trail was in place. The pharmacy used a domestic-grade fridge to store medicines that needed cold storage. The medicines inside were tidily stored. The pharmacy didn't keep complete records of daily fridge temperature ranges. Temperature ranges were only recorded on three days in January 2022. The fridge was operating slightly outside of the correct temperature range on the day of the inspection. Following the inspection, the RP sent the inspector daily temperature logs for the five days after the inspection. The logs showed the fridge was operating within the correct temperature ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. And it appropriately uses its equipment to protect people's private information.

Inspector's evidence

The pharmacists had access to up-to-date reference sources. The pharmacy used a CE quality marked measuring cylinder for liquids. The computers were password protected to prevent any unauthorised access. Team members had access to personal protective equipment including face masks and gloves.

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.