General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Phlo - Digital Pharmacy, Unit 12 -14, Containerville, 35 Corbridge Crescent, E2 9EZ

Pharmacy reference: 9011535

Type of pharmacy: Internet / distance selling

Date of inspection: 11/10/2023

Pharmacy context

The pharmacy is in a small container park in a largely residential area. It provides its services at a distance, and it receives most of its prescriptions electronically. It dispenses NHS and private prescriptions and the and is not physically accessible to the public. The pharmacy’s website can be found at www.wearephlo.com.

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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
2. Staff	Standards met	2.5	Good practice	The pharmacy has regular meetings and team members are encouraged to contribute. It actively seeks team members' feedback and input before changes are made to the pharmacy systems.
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 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 any future risk. It generally protects people's personal information well. And people can feed back about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

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. 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 identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were routinely recorded and regularly reviewed for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Following a dispensing mistake, the pharmacy had developed an update to the computer system to include an additional check on the dispatch label. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong directions had been put on the dispensing label. The pharmacy had been trying to standardise the instructions on labels which meant some information had to be altered manually at the pharmacy. The pharmacy was in the process of changing its processes to help minimise a similar occurrence.

Workspace in the dispensary was 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. And to transport medicines and prescriptions between the dispensing and checking areas. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. There were usually two pharmacists working and the pharmacy employed locum pharmacists to provide cover where needed. The second pharmacist said that the locum pharmacists were trained to use the pharmacy's computer systems. He said that the pharmacy would remain closed if there was no pharmacist available. Following the inspection, the superintendent pharmacist explained that the pharmacy had a strong contingency plan. And that the pharmacy had not had to close due to a pharmacist not being available.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed. The RP record, private prescription records and controlled drug (CD) registers examined were filled in correctly. And the CD running balances were checked at regular intervals.

Confidential waste was removed by a specialist waste contractor. Computers were password protected

and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Team members had completed training about protecting people's information.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The second pharmacist said that complaints would be dealt with by the head of patient care or the SI, and he was not aware of any recent ones.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The second pharmacist could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the relevant authority. The second pharmacist said that there had not been any safeguarding concerns at the pharmacy. And 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 trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There were two pharmacists, one regular full-time dispenser and two locum dispensers working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

The pharmacists were aware of the continuing professional development requirement for professional revalidation. The second pharmacist had completed training about the green inhaler initiative about reducing the carbon footprint. As a result of this, the pharmacy now stocked more dry powder inhalers.

New team members underwent a six-month probation period. During this time, they completed various training modules, including the dispensing processes and data entry. Their competencies were checked before being signed off. The second pharmacist said that they were regularly supervised, and they received additional support or guidance if needed. They had access to dummy systems so that they could practice without interfering with the pharmacy’s main computer system. And there were online videos available about how to use the pharmacy’s computer systems. There were also system guides for them to refer to if needed. Team members were received regular updates about changes to systems. An accuracy checking dispensary assistant had recently left the company. The second pharmacist said that he was waiting for confirmation that one of the dispensers had been enrolled on the checking course.

The pharmacy had regular meetings and the head of operations had weekly meetings with the pharmacy managers. There was a monthly clinical meeting with the head of patient care, the SI, chief pharmacist, and pharmacy manager. The pharmacy managers and dispensers were involved with the product team so that they had input and provided feedback on the functionality and design of the new computer systems before implementation.

The pharmacists felt able to make professional decisions. There were weekly team meetings to discuss date checking, filing, any stock or logistical issues. A record of the meetings was sent to the SI and head of operations. The second pharmacist said that all team members could contribute at meetings. Team members had regular performance reviews with the SI. Targets were not 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. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy in a gated area and access could be gained by using the intercom system. The gated area also housed several containers which were used by other businesses. The pharmacy was spread over three container units on the ground floor and each unit was bright, clean, and tidy throughout. Air conditioning was available, and the room temperatures were suitable for storing medicines. Different tasks were undertaken in separate units, such as dispensing and packaging.

Toilet facilities were available in a container opposite the pharmacy. They were clean and not used for storing pharmacy items. There were separate hand washing facilities available. The second pharmacist said that there were regular fire alarm tests in the container complex.

The pharmacy's website provided people with information about the company and how the pharmacy managed their prescriptions. And it provided information about a variety of medical conditions. There were blogs on the website and all information in these was reviewed by a pharmacist and the SI before being added to the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And 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. The pharmacy manages prescriptions for higher-risk medicines well to ensure that people are having the relevant blood tests.

Inspector's evidence

People could contact the pharmacy via telephone, email, or live online chat. There was a dedicated patient care team to handle queries and concerns and chase repeat prescription requests.

The patient care team managed prescriptions for higher-risk medicines such as warfarin and lithium. The second pharmacist said that people were asked to provide a photo of their monitoring record book. This made easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. And the patient care team would speak with people about their medicines if needed before the prescription was processed. The pharmacy team was provided with this information so that it was available during the dispensing and checking processes. And a record of the blood test results was kept at the pharmacy. The second pharmacist 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 only dispensed this medicine in full packs. And people would be referred 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 second pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. And this made it easier for the pharmacy to show what it had done in response. The pharmacy's head office monitored this process to ensure that the drug alerts and recalls were dealt with promptly. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. The second pharmacist said that there had not been any returned CDs since the pharmacy had opened. He said that the pharmacy could arrange for the items to be returned to the pharmacy via a courier. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

If a prescription could not be dispensed in full, it was put on hold with a reason code and resolution date. People received an email to inform them about any issues and they were offered the option to have their prescription returned to the NHS spine. The pharmacy's head office analysed the part dispensed prescriptions and used this information to inform stock levels.

Deliveries were made by a variety of couriers using tracked delivery services. The deliveries were tracked using GPS and all were required to be signed for upon delivery. Insulated packaging was used to package items requiring refrigeration. Failed deliveries were returned to the depot for safe storage and people were asked to rearrange delivery. The pharmacy was made aware of all occasions where a delivery had not been made.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. 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.

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.