General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Verdun Pharmacy, 1 Verdun Road, London, SW13 9AN

Pharmacy reference: 9011621

Type of pharmacy: Internet / distance selling

Date of inspection: 22/02/2024

Pharmacy context

This is an independently owned pharmacy. The pharmacy is closed to the public and offers its services over the internet only. It does this through its website https://www.verdunpharmacy.co.uk/. It is in small premises attached to a local convenience store. And it is in a residential area of Richmond. It dispenses electronic prescriptions. And it delivers medicines to people. It can also supply of over-the-counter medicines and other pharmacy related products.

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 suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy mainly dispensed and supplied medicines from NHS electronic prescriptions. But it also supplied medicines for a small number of private prescriptions. Since opening almost two years previously prescription numbers had increased. And so, the Responsible Pharmacist (RP), who was also the superintendent (SI) had recruited additional team members. He had recently recruited a part-time locum. And a part-time member of staff whom he had begun training as a dispensing assistant (DA). He had also recruited occasional help with deliveries from his fellow company directors. And on occasion used the Royal Mail track and trace service to ensure that people got their medicines on time. He had done this to reduce pressure on himself and his time. And to help manage the increase in workload overall. The pharmacy had a system in place for recording its mistakes. But it had not yet used it. The RP described how he generally highlighted and discussed 'near misses' and errors as soon as possible with the staff member concerned to help prevent the same mistakes from happening again. The team did not appear to make many mistakes. But when it did, it discussed them. While it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, by not keeping records it did not fully capture the detail of what team members had learned or how they would improve. The RP, and inspector discussed this and agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. And by recording what had happened. And any follow up actions, it would also help the RP to monitor learning. And support improvement more effectively.

The RP worked at the pharmacy full-time. And he worked directly with the new trainee DA and delivery helpers to ensure they understood the procedures they should follow. Delivery helpers had been briefed on the procedures to follow when delivering a controlled drug. This included what to do if the delivery was unsuccessful. When delivering a CD, the RP supplied delivery helpers with a form signed by both the RP and delivery helper authorising them to carry the CD and detailing what to do if the CD could not be delivered. He used this form to ensure there was no misunderstanding of the correct process to follow. The pharmacy had up-to-date standard operating procedures (SOPs) in place. But while team members had been briefed, they had yet to read and sign those relevant to their roles. The RP agreed that all team members would read and sign the appropriate SOPs. The RP had placed his RP notice on display showing his name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. People also left comments and gave feedback on the pharmacy's website or by email. Since beginning services to supply medicines to three local care home environments, the pharmacy had received many positive comments about its services. It was clear that the RP went out of his way to make deliveries out of hours when the homes needed him to. And he listened to them. He described

how one of the homes had asked him to amend the medicines administration record (MAR) chart to help them to manage people's medicines administrations more effectively. And so, he had contacted his software provider to amend and improve the chart. As the home found the new chart useful, he introduced it successfully for the other homes. The pharmacy had a complaints procedure to follow if needed. And the RP knew how to provide people with details of where they should register a complaint if they wanted to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP worked with surgeries to arrange for alternatives when they received a prescription for an item that they could not get. The pharmacy also tried to keep people's preferred brands of medicines in stock so that their medicines were available for them when they needed them. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its RP records, records for emergency supplies. And its controlled drug (CD) register. The pharmacy kept a record of its CD running balances. And a random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy's private prescription records were generally in order. But it was not fully up to date with some prescriptions still to be entered in the register. The RP was aware that he needed to update the records. And it was clear that he understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy was closed to the public. And so, people's personal information, including their prescription details, were out of public view. Delivery drivers and other non-pharmacy staff came to the front door or staff toilet area but did not enter the dispensary. The RP had briefed team members, including those who occasionally helped with prescription deliveries, on the need to protect people's confidentiality. And he checked their understanding to ensure that people's private information remained protected. The pharmacy discarded its confidential paper waste into a separate container. And team members shredded it throughout the day, as they worked. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. It had not had any safeguarding concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy regularly reviews its workload and ensures that it has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback, so that they can maintain the quality of the pharmacy's services.

Inspector's evidence

The RP was a director of the company which owned the pharmacy. The company was a family business. And it owned the convenience store that the pharmacy was attached to. The RP ran the pharmacy independently of the convenience store. But was supported by the company's other directors, whom he had trained to assist him with prescription deliveries. The pharmacy had also recruited a part-time locum. The locum worked separate shifts to the RP and covered the days that he was not in the business. The pharmacy had also recently recruited a part-time trainee DA. The trainee had worked at the pharmacy for less than two months and so, had not yet been registered on a recognised DA training course. But the RP had monitored her progress and proposed to put her on the course in the next few weeks. The RP had coached the trainee to recognise, and look out for, the differences between look-alike sound-alike medicines (LASAs). And he explained the uses for different medicines as they worked. He also encouraged her to ask questions about anything which was new to her. The pharmacy was up to date with the workload. This included attending to people's queries. The RP was able to make his own professional decisions in the interest of patients. He could also raise concerns with the company's other directors if he needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was in a room converted from a back shop area of the convenience store. The pharmacist’s fellow director from the convenience store had been briefed on pharmacy security and patient confidentiality. And he did not access the dispensary. The pharmacy had a compact dispensary. It was small and narrow. But it had just enough space for team members to dispense the pharmacy’s multi-compartment compliance packs. It had worksurfaces on two sides which were used for the pharmacy’s dispensing activities. And it had storage facilities above and below the worksurfaces. It had an area for dispensing and checking. And an area for packing medicines for delivery. The pharmacy had a regular cleaning routine. And it kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment frequently. Team members cleaned floors daily. And they tried to keep them tidy. But it was clear that as the pharmacy’s prescription volume increased, free space had become limited. The RP described his plans for relocating the pharmacy to an area with a larger floor space within the same building to provide a more appropriate environment for the workload. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy offered its services over the internet. And so, people registered for its services on the pharmacy's website, giving their consent and their doctor's details. People requested their prescriptions through the website or through the pharmacy's smartphone 'app.' And they could use the app to track the progress of their prescription and set up reminders to place their repeat requests. After receiving people's details, the pharmacy accessed their prescriptions from the NHS spine. The RP also requested repeat prescriptions for people who wanted or needed him to. The pharmacy's website gave its times of operation. And a description of its services. The pharmacy could deliver prescriptions across the UK. But most people using its services lived within the local area. The pharmacy provided multi-compartment compliance packs for people living at home who needed them. And for people living in a small number of local care homes. The compliance packs used were disposable and clean. And they had been labelled with a description of each medicine, including colour and shape, to help people to identify them. The pharmacy supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines.

The RP gave people advice on a range of matters. He did this through the pharmacy's online chat facility, by telephone or by video call. And he gave appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also knew to provide warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs. The pharmacy used a third party pharmacy provider to supply Pharmacy (P) medicines The third party provider monitored the sales of P medicines and made the supplies after people had successfully completed a questionnaire. But the pharmacy also received requests directly from people. And so, the RP monitored the amount and frequency of requests for P medicines to make sure people's health was protected.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. But the inspector found three small number of amber dispensing bottles containing loose tablets in amongst stock. Two bottles had a label identifying the name and strength of contents. And one was unlabelled. And so, they did not contain all the required manufacturer's information about the tablets inside. The RP was confident about the identity of the contents. And he could describe what they were. He had stored them this way very recently. And he used them for dispensing people's regular compliance packs. And so, the risk of error was low. But packaging medicines in this way may

mean that the contents could be missed if subject to a recall or an expiry date check. The RP agreed that he should review his procedures for putting medicines back into stock after dispensing.

The pharmacy checked the expiry dates of its stock, regularly. And it kept records. When the team identified any short-dated items it highlighted them. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had a computer terminal in the dispensary. The computer had password protection. The RP used his smart card to maintain an accurate audit trail. And to protect people's private information. People did not generally have access to the pharmacy. And so, the pharmacy could protect their personal information appropriately. The pharmacy had a shredder which it used regularly to dispose of confidential paper waste.

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.