General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Gloucestershire Pharmacy, 18 Darwin Close, Cheltenham, Gloucestershire, GL51 0UE

**Pharmacy reference:** 9011840

**Type of pharmacy:** Internet

**Date of inspection:** 21/10/2022

## Pharmacy context

This is an online pharmacy based in Cheltenham, Gloucestershire. It dispenses NHS prescriptions and offers a delivery service. People can use the pharmacy for some NHS-funded services. And it sells a range of over-the-counter products through its website. A main focus of the pharmacy is preparing multi-compartment compliance packs for people who need them, including those living in residential care homes. And medicines are delivered to people as the pharmacy is not open to the public to visit.

## 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 generally manages risks associated with its services. Team members have clear written procedures to follow and they know their roles and responsibilities. There is an open culture when things go wrong, and they take time to learn from their mistakes. But there were no risk assessments or audits on pharmacy services completed. Records are generally maintained accurately. And confidential information is securely handled to protect people using the pharmacy. The pharmacy team know how to protect vulnerable people and how to raise concerns. The pharmacy has appropriate indemnity insurance cover in place.

### Inspector's evidence

There was a range of standard operating procedures (SOPs) at the pharmacy. These were prepared by a third party and approved by the superintendent pharmacist (SI). These SOPs were recently prepared as the pharmacy only opened this year. The SI explained she intends to review SOPs on an annual basis or sooner, if an incident occurs. The SOPs were read and signed by the sole dispenser working at the pharmacy. And they explained they were confident working in a pharmacy and had experience working as a dispenser at a previous pharmacy. The SI explained that she checked the dispensers understanding of the SOPs by discussing them together. The SI and dispenser logged any mistakes which were identified before medicines were given to people (so called 'near misses'). And logs for a range of months were inspected during the visit.

The SI explained that she reviewed near misses and discussed them with the dispenser regularly. The SI explained that they had not experienced any incidents where the wrong medicine was given to a person. But she described a recent concern from a person's family around changing the persons nominated pharmacy to this pharmacy. The pharmacy team learned from this incident and have changed their practice to record who has given consent for a pharmacy nomination to change. They recorded these on a 'Patient nomination data collection form' for future reference. The SI reported this complaint to the NHS at the time. And documented the nature of the complaint along with what was done to rectify this. The pharmacy had a complaints policy and the SI showed this to inspectors during the inspection. The pharmacy team received informal feedback from people who used the pharmacy. And the pharmacy's website contained details around making complaints and provided an email address for this purpose. People could also telephone the pharmacy to complain or provide feedback. The pharmacy had not completed any risk assessments relating to their services. And there were no audits completed on working practices or services provided. There was no audit trail to identify who had completed different professional activities, such as preparing multi-compartment compliance packs. But the SI agreed to implement these in future.

The pharmacy dispenser was experienced and understood their role. She correctly explained what things could and could not be done in the absence of a responsible pharmacist. And she felt confident to ask the pharmacist for support if something went wrong. The pharmacist had completed level 2 safeguarding training. And the dispenser had been trained on safeguarding in a previous role. The pharmacy had access to contact details for local safeguarding contacts. And were aware of how to raise concerns with the GP surgery if needed.

The pharmacy generally maintained the records it was required to by law. The Responsible Pharmacist

(RP) record was generally completed accurately. But there were instances when the absence of the pharmacist during lunch was not recorded. Feedback was given to the SI regarding this who undertook to maintain an accurate RP record in future. The pharmacy had not received any private prescriptions since opening. But the SI explained that their patient record system was able to keep a private prescription record if they receive any in future. The pharmacy had not supplied any unlicenced medicines therefore did not have any records for these. But the pharmacy had a SOP covering the supply and recording of unlicenced medicines. Fridge temperature records were maintained appropriately and were available to see during the inspection. And controlled drug (CD) records including receipt, supply, balance checks and destruction were correctly maintained.

The pharmacy appropriately disposed of confidential waste. There was a shredder in the pharmacy which the pharmacist and dispenser used to destroy confidential waste. The SI explained the delivery driver received training on confidentiality and data protection. Computers were password protected. And the pharmacist and dispenser used their own NHS smartcards to login to the pharmacy computer system. The pharmacy had appropriate indemnity insurance and a certificate was displayed at the premises.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

This is a small pharmacy team who work well together and understand their roles and responsibilities. There are enough team members who are appropriately trained to complete their roles. There is an open culture among team members. And workload is completed in a timely manner with no evidence of backlog.

### Inspector's evidence

The pharmacy team consisted of a pharmacist, a trained pharmacy dispenser and a delivery driver. The pharmacy dispenser was experienced and qualified from a previous dispenser role in another pharmacy. The team were able to complete key tasks and there was no excessive backlog with dispensing prescriptions. So the workload was manageable and there were enough staff to ensure the pharmacy ran safely and effectively.

The pharmacy dispenser and pharmacist appeared to work well together and had a good rapport. The pharmacy dispenser explained she felt supported in her role. And was able to make suggestions and seek support from the pharmacist when needed. She confirmed she felt able to communicate any learning needs she has to the pharmacist.

Near misses were discussed in a supportive way and there appeared to be an open culture. The SI had weekly ‘governance meetings’ with the dispenser and discussion points were recorded on a dedicated proforma. These records were reviewed during the inspection and show dates and signatures of the pharmacist and dispenser. Key points included recent near misses and shared learning identified throughout the week. As the pharmacy had recently opened, there were no records of appraisals being completed. The pharmacist and dispenser informally discuss working practices. An example of a change to working practices was the implementation of a cleaning and rotation rota for medicines as stock levels increased.

The atmosphere at the pharmacy seemed calm and organised. And the dispenser appeared confident in her role. She was observed during the inspection answering calls from people using the pharmacy in a professional manner. The pharmacy team also included a delivery driver who was not present at the inspection. The SI explained that the driver was aware how to contact and seek advice from the pharmacist if needed during deliveries.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises offers a clean, secure and professional environment for the services provided. The pharmacy has a logical workflow and sufficient space for team members to work safely. The pharmacy's website complies with GPhC guidance.

### Inspector's evidence

The pharmacy was located in a renovated premises in a residential area. It consisted mainly of a small dispensary with a consultation room. It was not open to the public for visiting. The pharmacy appeared clean, hygienic and well maintained. There was a cleaning schedule in place and the SI explained that the team cleaned the workspaces at the end of each day. There were separate work stations for preparing medicines and dispensing. And there appeared to be a logical flow to the workspace. There was hot and cold running water with soap available. And a separate area for the preparation of medicines requiring reconstitution. Information relating to people using the pharmacy was stored appropriately and securely.

There was a small consultation room which was used to store a range of items including medicines awaiting destruction. But this was not used for in-person consultations as people did not visit the pharmacy in person. The consultation room was appropriate to be used as a place to have sensitive telephone consultations if needed.

The pharmacy was secured from unauthorised access. And there were appropriate key holding arrangements in place. The CD cabinet was secure and protected from unauthorised access. The pharmacy had appropriate lighting for safe working and temperature for the storage of medicines.

The pharmacy had a website for people to use to access information about the range of services on offer, learn about a range of health conditions, and to purchase general over-the-counter medicines and associated products. The website displayed the required information on the name of the SI, the address and contact details of the pharmacy, how to raise a complaint and associated registration numbers of the pharmacy and the SI. The range of products available via the website did not include any prescription only medicines and the pharmacy was not associated with a prescribing service at the time of the inspection.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides a range of services to people. And it generally manages its medicines safely. Information about peoples prescriptions is communicated securely with other health providers. The pharmacy team manage medicines associated with higher risk safely and provide people with written information about higher risk medicines when required. Medicines are obtained from appropriate sources and stored appropriately.

### Inspector's evidence

The pharmacy was located in a premises which the public cannot access in person. People could access the pharmacy team and pharmacy services through use of a telephone number and a website. The website contained details of pharmacy services available, details on how to contact the pharmacy team, opening hours and how to raise a complaint. Local GP surgeries contacted the pharmacy using secure NHS email or telephone.

The pharmacy offered a range of services including delivery of medicines, providing multi-compartment compliance packs to people who need them, the New Medicines Service (NMS), the Discharge Medicines Service (DMS) and the Community Pharmacy Consultation Service (CPCS). These were advertised on the pharmacy's website with details on how to request such services.

The pharmacy dispenser explained the process followed for preparing multi-compartment compliance packs. The pharmacy obtained consent from people requiring these packs and then arranged for prescriptions to be sent to the pharmacy from the local GP practice. Any changes to prescribed medicines were communicated between the GP practice and pharmacy using secure NHS email. Or through the PharmOutcomes platform which the pharmacy used to receive any discharge summaries from hospitals.

People received patient information leaflets on a monthly basis for all medicines included in the packs. Medicines associated with higher risks or subject to frequent dose changes were not included in the packs but supplied in separate containers. These included methotrexate and warfarin. The pharmacy did not include descriptions of what different medicines looked like when they prepared the multi-compartment compliance packs. Inspectors explained that people using these packs need to be able to identify the medicines inside. And the SI agreed to include descriptions of medicines in packs in future. The delivery service was organised through a dedicated mobile application which logged which deliveries were scheduled on a given day. The delivery driver returned any undelivered medicines to the pharmacy before closing. And no deliveries occurred unless a responsible pharmacist was signed in. The driver was able to call the pharmacy to seek advice if needed. And notification cards were left at people's homes for any failed deliveries. The SI showed inspectors how the pharmacy uses PharmOutcomes to receive referrals for the NMS, DMS and CPCS.

The pharmacy had supplies of patient information booklets for medicines associated with higher risks, for example lithium and anticoagulants. And the pharmacy had steroid emergency cards to supply to people who needed them. The pharmacy team were aware of the additional checks needed when supplying medicines containing sodium valproate to people at higher risk of adverse effects. The SI knew to check that a pregnancy prevention programme was in place if applicable. And the pharmacy

had valproate information cards to supply along with these medicines. The SI advised that the pharmacy did not currently know of medicines containing sodium valproate being supplied to anyone in the higher risk groups through their pharmacy.

Medicines were prepared and checked by separate people. But there was no audit trail in place to identify who completed each task. The SI accepted this practise was associated with additional risks and undertook to implement an audit trail for dispensing medicines. The pharmacy used barcode technology to reduce the risk of accidentally preparing the incorrect medicine. But there were some bottles containing medicines which were removed from the manufacturers packaging without details of the batch number or expiry date. The SI accepted this was associated with additional risks and agreed to transpose batch numbers and expiry dates for these medicines in future. There were no audits on pharmacy services completed at the time of the inspection. The SI was advised of the importance of clinical audit and agreed to establish audits for assurance. Medicines were obtained from registered wholesalers. And the pharmacy had a process in place to regularly check expiry dates of medicines held as stock. There was a dedicated fridge to store medicines requiring cold storage. And the temperature of this was regularly monitored by the team to make sure it was within the required range. The pharmacy had a system to receive alerts about medicines. And these were printed by the SI, actioned appropriately and stored for future reference. CDs were securely stored, and balance checks were completed and recorded weekly. No discrepancies in balances were identified during the inspection. Medicines awaiting destruction were segregated from regular stock. And the SI was organising a third-party service to remove and destroy these medicines.

The pharmacy website hosts a service where people can order a range of general health medicines online. This service is provided through a third party and no medicines subject to abuse or misuse were identified on the website. The SI explained that the processing of these orders was completed by the third party, including the delivery service.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the required equipment to provide services safely. And equipment is cleaned regularly. Team members have access to information they need to do their jobs.

### Inspector's evidence

The pharmacy had a range of validated measuring cylinders for measuring liquid medicines. These were cleaned after use and stored appropriately. There were tablet counters available and separate equipment was used for cytotoxic and non-cytotoxic medicines.

The pharmacy team had access to appropriate, up to-date reference sources online and via mobile apps to help them with their roles, including the BNF and BNF for Children. The pharmacy had internet access. And the single computer terminal in the pharmacy was sufficient for the current workload to be completed safely. The pharmacy had a telephone to answer calls from people using the pharmacy. NHS smartcards were used by people to whom they belonged. Electrical sockets had stickers to confirm recent testing had been completed.

## 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. |