General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Orange Pharmacy, 237 London Road, Reading, Berkshire, RG1 3NY

Pharmacy reference: 9011875

Type of pharmacy: Internet / distance selling

Date of inspection: 24/07/2023

Pharmacy context

Orange pharmacy is an independent community pharmacy. The pharmacy is on a parade of local shops and businesses in a suburb of Reading in Berkshire. It provides its services over the internet and is generally closed to the public. It focuses on dispensing services and the delivery of NHS prescriptions. But it also provides winter flu vaccinations and a microsuction ear wax removal service. It hopes to extend its range of services to include travel vaccinations.

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 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 adequately 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 offered its main services over the internet. The most frequent visitors to the pharmacy were delivery drivers from the pharmacy's wholesalers. And occasionally people for the microsuction ear wax removal service or flu vaccinations in winter. The regular responsible pharmacist (RP) was also the superintendent (SP). The pharmacy had relocated to its current, larger premises approximately 18 months previously. It had done this to provide better space for its dispensing activities, which had increased since the business first opened. The SP hoped to increase the range of services on offer over time.

The pharmacy had an NHS contract. And most of the prescriptions it dispensed were NHS electronic prescriptions. It had also dispensed a small number of electronic private prescriptions and paper prescriptions. People could register their details on the pharmacy's website or by making direct contact with the pharmacy. And after they gave their consent and their doctor's details, the pharmacy could access their prescriptions. The pharmacy also requested repeat prescriptions for people who wanted or needed them to. But people could also request their prescriptions through the pharmacy's website. Or directly with the surgery. The pharmacy had a system to set a reminder for when they needed to order people's prescriptions next. The pharmacy's customers generally lived in the local area. And so, the pharmacy delivered their medicines to them.

The pharmacy had a system in place for recording its mistakes. The SP RP described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. The team had been made aware of the risk of confusion between look-alike sound-alike medicines (LASAs). And it had identified the possibility that mistakes could occur between them. These included medicines such as such as amlodipine and amitriptyline. The team was aware that when they were dispensing a LASA it should prompt an additional check of the item they were selecting. But while the team usually recorded its mistakes, it did not fully record what team members had learned or what they would do differently next time. The SP RP reviewed the records periodically. But he agreed that if the team had more details of what it had learned from its mistakes, along with more frequent reviews, he could monitor them more effectively. He agreed that this would provide team members with a better opportunity to learn. And it would help them to identify follow up actions.

The pharmacy had standard operating procedures (SOPs) in place. Team members had all read the SOPs. And they understood their roles and responsibilities. The dispensing assistants (DAs) consulted the pharmacist when they needed his advice and expertise. And they accessed, used and updated the pharmacy's electronic records competently. During the inspection, the SP RP placed his RP notice on

display showing his name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. The pharmacy's website provided information on how people could contact the pharmacy if they had any queries or were experiencing problems with the service. And it provided an email address and a phone number for people to use. The SP RP could provide details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. But he generally dealt with people's concerns at the time. In general, the pharmacy got feedback by email or on the phone. But it often got feedback directly from people at the time of delivering their prescriptions. Approximately 18 months previously some people had raised concerns that the pharmacy had tried to deliver their medicines when they were not at home. So, they then had to arrange a second delivery. And so, the team had introduced a system where it texted people to offer them a time slot. This had worked well with most deliveries now happening successfully the first time. In response to other feedback, the pharmacy tried to keep people's preferred make of medicine in stock so that it always had them, if available from the suppliers. In general, the pharmacy received positive comments. It had received positive comments from people who preferred not to have to visit a pharmacy to get their medicines. And who could still talk to a team member if they needed to.

The pharmacy generally kept its records in the way it was meant to, including its controlled drugs (CD) register and its RP records. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy also kept appropriate records of its private prescriptions. And although it had not had many emergency supplies, its emergency supply records were also complete and up to date.

The SP RP understood the need to protect people's confidentiality. And the importance of observing GDPR and data protection laws. The pharmacy delivered people's medicines directly to their place of residence. And it did not leave them unattended. The pharmacy team shredded its confidential paper waste. And it worked with online systems which had been encrypted. People did not generally enter the pharmacy, so people's prescription details could be kept secure. The SP RP had completed appropriate safeguarding training. He knew where to report any concerns. And he could access details for the relevant safeguarding authorities online. But he had not had any specific safeguarding concerns to report. Team members had been appropriately briefed and they knew that if they had any concerns, they should report them to the SP RP for action.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another appropriately. In general, they are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service

Inspector's evidence

On the day of the inspection the SP RP worked with a dispensing assistant (DA) who was also the pharmacy's manager. And three further DAs. A delivery driver was also on duty delivering prescriptions. The pharmacy had an additional locum pharmacist each Friday to help complete the workload for the weekend. The team kept the daily workload of prescriptions in hand. And it attended promptly to people's emails and phone calls. Team members worked on their allocated tasks at their designated workstations. And they appeared to work efficiently with one another. The pharmacy also supported the work placement training of pharmacy students from the local university. And it had recently become an official training provider for it. The SP RP had arranged for two students at a time to work at the pharmacy from the start of the new term in September.

With a high turnover of prescriptions the SP RP was in demand throughout the inspection. He described how he had recruited an accuracy checking technician (ACT) who would start work the following week. He had recruited the skills of an ACT to support him with the final accuracy checking of prescriptions. And to allow him to attend to other tasks which required the expertise and skills of a pharmacist. The SP RP had also recently recruited the DA manager from existing staff to help with the overall running of the pharmacy. Including management of staff, administrative tasks and communications with patients. But this was a new post. And the role was still evolving as the DA gained management experience. Other DAs were observed managing repeat prescriptions and getting prescriptions ready for delivery. The RP SP felt he could make day-to-day professional decisions in the interest of patients. Team members described being able to discuss their concerns with the RP. But due to the demands of the day-to-day workload they did not currently have regular meetings or appraisals about their work performance. And so, the pharmacy team may not have enough opportunity to have its concerns raised with senior management or addressed by them. The inspector and SP RP discussed that within an expanding team, it was important that team members were able to raise concerns and discuss their performance. So, that they continued to feel a valued part of the team. And to help them improve their performance and develop in their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are bright and well lit. And they are generally tidy, and organised. They are also sufficiently clean and secure.

Inspector's evidence

The pharmacy occupied a traditional retail unit on a parade of local shops and businesses. It kept its door open, but members of the public did not generally enter the pharmacy unless they wanted to make an enquiry about its services. Or if they required ear wax removal or a flu vaccination. The pharmacy had a reception area next to the entrance, where the DA manager usually worked. She was stationed here so that, while she worked, she could greet people when they entered, answer their queries or signpost them as appropriate. The pharmacy had two desks at the reception area with a computer terminal on each one. Both desks had raised screens in front of them to help prevent people from seeing any private information which team members may be properly accessing. And it had opaque windows along its outside front wall which helped to make its environment bright and well lit, while protecting privacy. The pharmacy also had a consultation room. And it had a waiting area. The pharmacy used the consultation room for its ear wax removal service and flu vaccinations. But the SP RP proposed to use it more often in future once he had introduced a travel vaccination service.

The pharmacy had two spacious dispensing areas. A full height shelving unit separated the two areas. The front dispensing area had a central island for dispensing. And it had a run of shelves and drawers for storing medicines. The front dispensary was where the pharmacy dispensed most of its repeat and urgent prescriptions. The rear dispensary was where the team dispensed its multi-compartment compliance packs and processed its prescriptions. The rear dispensing area also had a central island. And it had a run of dispensing work surface around its walls. It also had additional storage above and below for medicines and medical appliances. The SP RP accuracy checked prescriptions both here and at the front dispensary.

The pharmacy had a cellar which it used for storing non-medicinal items. And it had a sink with hot and cold running water. And it had a staff area and further storage to the rear. The team cleaned the pharmacy's worksurfaces and contact points regularly to ensure that contact surfaces were clean. And work surfaces were free from unnecessary clutter. A cleaner attended once every two weeks to clean all areas. The premises were generally tidy and organised. Although at the time of the inspection the floor had a light cover of dust and debris in some areas. 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 it makes them accessible for people. The pharmacy gets its medicines and medical devices from appropriate sources. And it makes the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy generally stores its medicines properly.

Inspector's evidence

The pharmacy had large signage on its windows to advertise the availability of its services. And to promote its internet services. But people usually accessed its services through the pharmacy's website. The website also gave its hours of opening. And a description of its services. The pharmacy could order people's repeat prescriptions for them. It requested them two to three weeks before the next allocation of medicines was due. This gave the team enough time to obtain the prescription, sort out any problems and order stock. The team then assembled the prescriptions ready for delivery in time for their next medicines cycle, to ensure that they did not run out. The pharmacy provided multi-compartment compliance packs for people living at home who needed them. The compliance packs used were disposable and clean. The pharmacy had labelled the packs with the person's name, the name of the medicines and the approximate time at which they should take them. The labelling directions also gave the required advisory information to help people take their medicines properly. And they had a description of each medicine, including colour and shape, to help people to identify them. The pharmacy team also supplied its compliance packs with patient information leaflets (PILs) for all new medicines. And generally, with regular repeat medicines.

The SP RP gave people advice on a range of matters. He usually did this by telephone. And he gave appropriate advice to anyone taking higher-risk medicines. The SP RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had patients taking valproate medicines. But no one was in the at-risk group. The SP RP described the precautions he took, and counselling he would give, when supplying the medicines. And he supplied the appropriate leaflets and warning cards each time. The pharmacy had a fully trained member of the team who provided the ear wax removal service. She provided the service with the oversight of the RP. She had attended a two-day, face to face training session, provided by an established training provider. The pharmacy kept records of each consultation and demonstrated that people identified as not suitable for the process had been referred to another healthcare professional where appropriate.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. But the inspector found a brown dispensing bottle containing loose tablets which had a hand-written label with the name of the product, its strength and form, its 'lot' number and its expiry date. But the label did not contain any of the other manufacturer's information such as the product licence number. And so, they could be missed if they were part of a medicines recall. The inspector discussed this with the RP. And they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing.

The team date-checked the pharmacy's stocks regularly. And a random sample of stock checked by the inspector was in date. In general, the team identified and highlighted short-dated stock. And it put any

out-of-date and patient returned medicines into dedicated waste containers. The pharmacy stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. But it 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. And it keeps them clean. The pharmacy 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. The RP had access to a range of up-to-date reference sources. And as people generally did not visit the pharmacy, team members could hold private conversations with people on the phone. The pharmacy stored people's prescriptions out of view from any visitors to the pharmacy. And it had sufficient computer terminals at its workstations. Computers were password protected. And team members used their own smart card when working on patient medication records, so that they could maintain an accurate audit trail. And ensure that access to patient records was appropriate and secure.

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.