General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: iPharm, 2 Roundwood Drive, St. Helens, Merseyside, WA9 5JD

Pharmacy reference: 9011986

Type of pharmacy: Internet / distance selling

Date of inspection: 04/10/2023

Pharmacy context

This pharmacy supplies most of its services at a distance, and it is located in an industrial estate. The pharmacy dispenses NHS prescriptions which are supplied to people. It offers the New Medicine Service (NMS) and provides ear wax removal and the covid booster and seasonal flu vaccinations on site.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. The pharmacy keeps the records it needs to by law and has procedures in place to learn from mistakes. And it protects people's personal information appropriately. People can provide feedback about the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) were reviewed and made available to the pharmacy team members by head office. They had read and signed SOPs relevant to their roles. There was a SOP for the delivery of prescriptions. Following the inspection, the pharmacy group's area manager provided SOPs which directly related to the distance selling pharmacy activities.

Risk assessments were not available at the pharmacy during the inspection. Following the inspection risk assessments were provided. There was a separate risk assessment for the service as a whole, which looked at areas such as data security, prescription security, medication errors, and storage and security of medicines. A separate risk assessment had been completed for the sale of over-the-counter (OTC) medicines.

Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were corrected, recorded, and discussed with the team members. Near misses were reviewed over a period of time. But the responsible pharmacist (RP) or accuracy checking dispenser could not think of any changes that had been taken following the review of near misses. Warnings were attached to the shelf-edges where medicines that looked and sounded alike were kept.

Mistakes made during the dispensing process that hadn't been identified before being supplied to people (dispensing errors) were reported to head office and to the online National Reporting and Learning System (NRLS). A recent error included the supply of morphine tablets instead of capsules which had also been reported to the Controlled Drug Accountable Officer (CDAO). Following the error, prescriptions for CDs were checked multiple times before being supplied to help reduce the risk of similar mistakes.

The pharmacy had current professional indemnity insurance which covered all the services provided. The pharmacy had a complaints procedure and a complaints section on the website that people could use. The RP said there had not been any complaints since they had opened. The correct RP notice was displayed.

Private prescription emergency supply records, RP records, controlled drug (CD) registers and records of unlicensed medicines supplied were well maintained. Running balances were recorded and checked weekly against physical stock. A random balance was checked and found to be correct. A register was available to record CDs that people had returned.

The pharmacy had an information governance policy which had been read and signed by all team members to confirm they understood it. The pharmacy stored confidential information securely and

separated confidential waste which was then collected by a specialist contractor for disposal. The RP had access to summary care records (SCR) and obtained verbal consent from people before accessing. Team members who accessed NHS systems had individual smartcards.

Team members had all completed safeguarding training. The RP had a completed level two training. If the team had concerns, they would refer to the RP and were aware of the next steps to follow. The NHS safeguarding application was discussed with the RP who provided an assurance that she would look into it. Team members thought that all company drivers completed safeguarding training. Training records were kept at head office and were not seen during the inspection. Team members provided an assurance they would check what training drivers had completed. Training for delivery drivers was also discussed with the SI following the inspection, who confirmed that all drivers had completed level one safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. Its team members are able to discuss issues as they arise. And the pharmacy does some planning to assess its future staffing needs.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, a trainee dispenser and an accuracy checker (AC), who was based at the company's head office and was supporting the team. Other team members who were not present included a trained dispenser and two delivery drivers. The pharmacy was recruiting a dispenser to replace a team member who had recently left. COVID-19 vaccinations were provided to people by nurses. The RP felt that the team were able to manage the workload but once the new member of staff started things would become easier. The team were up to date with their dispensing.

The performance of the pharmacy team members was managed by the directors of the company. Team members were provided with feedback on an ongoing basis by the RP. As the AC worked at different stores, he was asked by the superintendent's team to provide feedback about the different pharmacies and ways in which they worked.

To help make sure team members were up to date, the head office team arranged ongoing training. The pharmacy team were sent a spreadsheet with details of the training they were required to complete. The spreadsheet also had details of when the training needed to be completed by. Team members were provided with time at work to complete the training. The RP was the supervisor for the trainee dispenser and supported her with her training. She was provided with time to complete the course.

The team was small and worked closely together. Issues and concerns were discussed as they arose or during team meetings that were occasionally held. The directors also attended the meetings. Team members felt able to feedback concerns and offer suggestions to both the RP and the head office team. One of the directors visited the pharmacy at least twice a week. Targets were in place for the pharmacy services provided. When questioned, the RP said these did not affect her professional judgment.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and secure. The pharmacy's website generally gives people information about who is providing its services, although some information is outdated. So people may not be able to contact the correct person if they need to provide feedback or discuss a concern.

Inspector's evidence

The pharmacy was situated in a large industrial property. The company's wholesale department was also located on the premises. The dispensary was situated to one side of the building and was clean and tidy, and there was ample workspace. There was a large hall which was used as a waiting area for the COVID-19 and flu vaccination services. A section of the hall had been separated using screens and was used for preparing multi-compartment compliance packs and storing medicines ready to be delivered to people. When questioned, the RP and accuracy checker explained that a wall was due to be built to create a separate room which would be inaccessible to anyone not working for the pharmacy. There were two clinic rooms, on was used to provide vaccination services and the other used as a storeroom. Cleaning was done by a cleaner.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare services.

The pharmacy had its own online website (https://ipharm.co.uk/). The website gave clear information how people could make a complaint, how people can contact the pharmacy and the GPhC registration information for the pharmacy and its owner. However, details of the SI pharmacist were incorrect. There were a limited number of over-the-counter medicines which could be purchased via the website. The RP said the pharmacy did not sell or supply any pharmacy medicines. However, these could be purchased from the website.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. Team members take the right action when safety alerts are received, to ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was a distance selling pharmacy so medicines were not supplied directly to people using the pharmacy. The pharmacy was open to people who were accessing services that it provided on site. The pharmacy website listed the services it provided and displayed the pharmacy's opening times. Prescriptions were predominantly received by the pharmacy electronically. However, on some occasions the driver collected paper prescriptions from doctor's surgeries for people who were nominated to the pharmacy. People were signposted to other services where appropriate and the team used the internet to find out details of services local to where the person resided. When the pharmacy was unable to supply medicines to people to take immediately, it returned the prescription to the NHS database and requested people try a local community pharmacy.

When received, prescriptions were checked against the record of what was ordered to identify any discrepancies. Prescriptions were clinically checked by the RP before being dispensed by the dispensers. Dispensed prescriptions were checked for accuracy by either the RP or AC. The AC did not check prescriptions for new medicines, CDs or high-risk medicines. He predominantly checked repeat medicines. The RP described that she would not self-check her own work and would ask a colleague to accuracy check if she had dispensed a prescription. 'Dispensed by' and 'checked by' boxes were available on dispensing labels, however, the 'dispensed by' boxes were not seen to be routinely used. This could make it difficult to identify team members who had been involved in the dispensing process if something went wrong. Baskets were used to separate prescriptions, preventing transfer of medicines between people.

People were counselled on the use of their medicines over the telephone if needed. Team members said people generally called the pharmacy if they had questions about their medicines. The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The team were aware of the labelling requirements and anyone who was in the at-risk group and not part of a PPP would be given the appropriate advice and referred to the prescriber. The pharmacy carried out checks on medicines that required ongoing monitoring. It's team members called people to check their INR results before supplying medicines containing warfarin and if they were having regular monitoring for other higher-risk medicines to help make sure they were safe to use.

Some people's medicines were supplied in multi-compartment compliance packs. Prescriptions for most people were ordered by the pharmacy and the packs were prepared by one of the dispensers. The pharmacy was notified of hospital admissions and received discharge summaries via PharmaOutcomes. Assembled packs were labelled with the product descriptions. Mandatory warnings were not included on backing sheets. The AC changed the settings when this was highlighted to them and provided an assurance that they would be included. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were provided annually, team members provided an assurance that they would start handing these out routinely.

The pharmacy's online business also involved the sale and supply of over-the-counter and pharmacy medicines (P) to people based in the UK. People were required to complete a questionnaire which was then reviewed by a pharmacist before orders were processed and shipped from the warehouse section of the premises. The area manager of the pharmacy explained that checks were completed by her or the superintendent pharmacist. A trained dispenser working in the warehouse would pick the orders that had been checked. The pharmacy did not supply codeine linctus over the internet because of concerns about misuse. Details of all sales were recorded and made visible to pharmacists reviewing orders. This helped the pharmacist to make a decision as to whether the medicine being requested was suitable. Evidence of orders that had been rejected were provided following the inspection.

The pharmacy provided a COVID-19 booster vaccination service following the national protocol guidance. The service was provided by nurses. The pharmacy also provided a blood pressure service. The RP felt the blood pressure service had a positive impact on the local population. She described when she had measured someone's blood pressure who was already taking medicines for high blood pressure but had high readings. In this case they referred them their GP for a same day appointment.

Some NHS prescriptions were received via an electronic application. Team members explained they had received between five to six prescriptions via this route from people residing nationwide. In the past medicines had been sent to London and Leeds. These medicines were sent out using a Royal Mail tracked delivery service. The pharmacy had a process for dealing with failed deliveries. Deliveries were carried out by one of two delivery drivers. Both had completed training at the pharmacy's head office. If people were not available to accept the delivery the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special storage consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. Date checking was done by the RP and recorded on a date-checking matrix. Short-dated stock was highlighted and recorded. A random sample of stock was checked, and no expired medicines were found. Out-of-date and other waste medicines were separated and collected by licensed waste collectors. Drug recalls were received electronically. The team would check the stock and take the action as required; a printed record was kept in the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. Equipment was clean and ready for use. Two medical fridges were available. A blood pressure monitor was used for some services provided which was fairly new. And the head office team dealt with calibration. The RP was unaware of the calibration arrangements and provided an assurance that she would look into this. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens were not visible to people using the pharmacy.

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.