General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Broadway Pharmacy with Cure Clinics, 1c Broadway, Fulwood, Preston, Lancashire, PR2 9TH

Pharmacy reference: 9012015

Type of pharmacy: Closed

Date of inspection: 18/10/2023

Pharmacy context

The pharmacy is located in a business address in Preston. The pharmacy premises is not open to the public. Its sole activity is the dispensing of private prescriptions for medicines prescribed by an online prescribing service specialising in ADHD conditions. Medicines are sent via mail order to people who have signed up to the pharmacy's service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	Controlled drug registers and private prescriptions are not kept in a format which meets the current requirements.
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 not all met**

Summary findings

The pharmacy team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy has written risk assessments to help show what the risks are with its services, and the action taken to help reduce these risks. Members of the team record things that go wrong and review them to help identify learning and reduce the chances of similar mistakes happening again. And they are given training so that they know how to keep private information safe. They make the records that are needed by law. But some of the records are not kept in an appropriate format.

Inspector's evidence

The pharmacy dispensed private prescriptions issued by a clinic which specialised in treating attention-deficit hyperactivity disorder (ADHD). The clinic was registered with the CQC. Consultations were provided remotely by UK registered prescribers. There was an electronic set of standard operating procedures (SOPs). Members of the pharmacy team had read the SOPs, and the electronic software recorded the date this was completed.

The pharmacy had carried out a thorough risk assessment for the services it provided. They had also assessed the risks associated with the way that the prescribing service provided its service and consultations. For example, it confirmed that the identities of people who accessed the prescribing service were checked using a photo ID which had been provided prior to an initial video consultation. The prescribing service also sought consent from people to share information with their GP. Where consent was not provided by a person who wishes to use the prescribing service, there were extensive procedures in place. This included a discussion with the person to explain how their decision to withhold consent may impact their health and care outcomes. After this discussion, if the person still did not want information to be shared with their GP, a risk assessment was carried out to decide whether it would be appropriate to issue a prescription. There were also escalation procedures in the event of a safeguarding concern. The prescribing service could not provide statistics for the number of people who had not provided consent to share information with their GP, other than deeming it 'incredibly infrequent'. The pharmacy had raised with the clinical team at the prescribing service the concern about not knowing how many people declined consent. As a result, the development team were creating functionality in their software to provide these figures. As part of the pharmacy procedures, all prescriptions were checked to ensure they were in line with the prescribing service's guidelines and formulary.

The pharmacist had carried out various audits to identify whether the pharmacy had been carrying out its processes correctly. These included auditing the prescriber's registration details, failed deliveries and the pharmacy's process to mark deliveries for "the parent or guardian of…" when the medicine was prescribed for a child. . For example, the pharmacy required medicines for children to be addressed to "the parent or guardian" of the child. But an audit had identified that 6.45% of the audit sample had not been marked in that way. To help address this, the pharmacist had provided training to members of the team, and was intending to complete another audit in December to see whether there had been an improvement.

The pharmacy kept records of dispensing errors and their learning outcomes. Near miss incidents were

recorded on electronic software. The pharmacist reviewed the records each month and discussed any learning points with the team. She gave examples of action that had been taken to help prevent similar mistakes. Such as making defined areas for stock in the controlled drug (CD) cupboards and marking the prescription to clearly differentiate between similar pack sizes of 28 and 30.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice on display. The pharmacy had a service level agreement with the prescribing service. Part of this involved a complaints procedure. Any complaints usually were reported to the prescribing service in the first instance and the details shared with the pharmacy. People could also report any complaints directly to the pharmacy. The pharmacy manager would investigate any complaints. A current certificate of professional indemnity insurance was on display.

Records for the RP and unlicensed specials appeared to be in order. Records for private prescriptions and controlled drugs (CDs) were available on electronic software. However, the records were shared with a pharmacy located next door that was owned by the same company. This meant the records of receipt, supply and running balances were not separated. This does not meet the legal requirements and made it difficult to audit the records to identify who had made each supply. A random stock check found the balance to be correct. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available, and members of the pharmacy team completed annual IG training. When questioned, a trainee dispenser was able to correctly describe how to segregate confidential information for it to be removed and destroyed by a waste contractor. People who used the pharmacy's services were provided with information which described how the pharmacy handled and stored their information. Safeguarding procedures were included in the SOPs. All members of the team had completed safeguarding e-learning. The pharmacist said she had completed level 3 safeguarding training. Contact details for the local safeguarding board were available. A trainee dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, a trainee pharmacy technician, a dispenser, four trainee dispensers, and a customer service advisor. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

The pharmacy provided the team with mandatory e-learning packages, such as fire safety, IG training and safeguarding. training programme. Team members were allowed learning time to complete training, and they were able to complete additional e-learning packages if it interested them. But as this was not required, some learning opportunities may be missed.

A trainee dispenser discussed how she would raise a query about an incorrect dosage instruction with the pharmacist if found whilst dispensing a prescription. The pharmacist felt able to exercise her professional judgement and this was respected by the superintendent (SI). Interventions were routinely recorded by the pharmacist on an electronic system. Records showed what the intervention was and the outcome. For example, the pharmacist had queried a prescription for two medicines which were not commonly prescribed together. As a result, the prescriber changed the prescription to an alternative medicine.

Team members were provided with monthly one-to-one meetings with the pharmacist manager. And members of the team held daily huddles to discuss the workload for the day. They were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no professional based targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And it is maintained to a standard expected of a healthcare setting.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. The temperature was controlled by the use of electric heaters. Lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. The pharmacist carries out additional checks using prescribing records to ensure they are being used appropriately.

Inspector's evidence

The pharmacy premises were not open to the public. People were referred to the pharmacy by the associated prescribing service, but they also had the option to take their prescription elsewhere. A link containing information about the pharmacy was provided by the prescribing service when people signed up to use the pharmacy's services.

The pharmacy initially received a scanned copy of the written prescription, so they could audit which prescriptions were due to be received by post. When the actual prescriptions were received, team members compared them to the scanned copies to ensure there were no missing prescriptions. A series of checks were completed by the pharmacy team, including the person's address, to ensure medicines were being delivered to the correct location.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The pharmacist completed a legal check of the prescription during their final checks, to help ensure the prescription would remain valid at the time of supply. The pharmacist also had access to the clinical notes, which were used when completing the clinical check to ensure the medicines were appropriate. The pharmacy also completed checks of the last time medicines were prescribed to ensure the prescribing intervals were appropriate. Examples were seen where the pharmacist had emailed the prescriber to confirm shorter than expected prescribing intervals and off-label prescribing. A record was kept as an audit trail of these conversations.

Medicines were packaged and sent to people using a national courier service. The pharmacy had a process in the event of a failed delivery. This involved contacting the patient to check their delivery details, and checking the prescription to ensure it remained in date.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked monthly, and a record was kept when this had been completed. The pharmacy highlighted short-dated stock using stickers. Controlled drugs were stored appropriately in the CD cabinets, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. Patient returned medication was disposed of in designated bins. Drug alerts were received on electronic software. Details of any action taken, when and by whom were recorded on the software.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. The pharmacy also had counting triangles for counting loose tablets. Equipment was kept clean.

Computers were password protected. A cordless phone was available in the pharmacy which allowed the team members to move to a private area if the phone call warranted privacy.

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.