General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Todmorden Pharmacy, 61A Halifax Road, Todmorden, West Yorkshire, OL14 5BB

Pharmacy reference: 9012037

Type of pharmacy: Internet / distance selling

Date of inspection: 18/10/2023

Pharmacy context

This pharmacy (https://todmorden-pharmacy.co.uk/) supplies most of its services at a distance, and it is located in a parade of shops opposite a large health centre. In addition to dispensing medicines, the pharmacy provides the New Medicine Service and Community Pharmacist Consultation Service. And it supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. And people can provide feedback about its services. It keeps the records it needs to keep by law, and these are largely kept accurate and up to date. And it protects people's personal information appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available, the responsible pharmacist (RP), who was also the superintendent pharmacist (SI) explained that SOPs had been reviewed at the beginning of the year and he was in the process of making them available electronically. Some pharmacy team members had not read the updated SOPs. The RP provided an assurance that they would read them. Team members had individual SOP training records and signed them once they had read and understood the SOP.

Risk assessments had been completed before the pharmacy had opened and were provided after the inspection. The risk assessments covered the services provided, identified the risks and listed the steps that the pharmacy had in place to mitigate these. The risk assessments were due to be reviewed at the end of the year.

Dispensing mistakes which were identified before medicines were supplied to people (near misses) were corrected, discussed with the team member involved in making the mistake and recorded in a book. The team held monthly meetings to discuss any trends, patterns and next steps, to ensure mistakes did not reoccur. Where a dispensing mistake had happened, and the medicine had been supplied to a person (dispensing errors), the RP would gather information and investigate what had happened. Dispensing errors were recorded electronically, and a printed copy was kept in the pharmacy. Following a recent error where amitriptyline 5mg in 5ml liquid was supplied instead of the prescribed amlodipine liquid, the person was referred to A&E and their GP was informed. The team had been briefed and both medicines were separated on the shelves. The RP said this medicine was not commonly dispensed, but team members now triple checked prescriptions involving these medicines. And they checked with the person at the point of the medicine being delivered.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and there was information on the website advising people how they could raise concerns or provide feedback, Care homes provided feedback when the SI visited. The RP said there had not been any complaints since they had opened. The RP notice was not initially displayed but a correct notice was displayed when highlighted. When questioned, some team members were not aware of the activities that could not be carried out in the absence of the RP. They were informed by the inspector and the RP provided an assurance that he would hold a discussion with the team.

Private prescription records, records for unlicensed medicines dispensed, RP records and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. Emergency supply records were kept but the reason for supply was not always recorded.CD balance checks were carried out infrequently. This could result in any discrepancies not being noticed promptly.

The pharmacy had an information governance (IG) policy; all team members had also completed IG

training. 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 it. Team members who accessed NHS systems had individual smartcards.

Team members had all completed safeguarding training and the pharmacists had completed level three training. Team members were aware of the reporting process but would refer any concerns to the RP. Details of the local safeguarding contacts were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to help safely manage its workload. Staff complete ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

At the time of the inspection the team comprised of the RP who was a regular pharmacist, six trained dispensers, three apprentice dispensing assistants and a new team member who had started working the day before the inspection. The pharmacy also had four delivery drivers who were not present at the time of the inspection. The RP planned to enrol the new team member onto the dispenser training course as the end of the week. Pharmacist cover was provided by the RP, another regular pharmacist and a regular locum pharmacist. Team members were split into two separate teams. One team covered the upstairs dispensary and the other worked downstairs. Absences were covered within the team and all team members were trained to work across both dispensaries. One of the dispensers had just qualified as an accuracy checker and the RP had plans to utilise them to check prescriptions. Team members appeared to be up to date with their workload.

Staff performance was managed by the RP. Team members were provided with feedback on an ongoing basis and had annual appraisals. The RP held short monthly meetings with individual team members to see how they were getting on.

Team members were all signed up to a training provider and had access to individual online training modules they could complete. Pharmacists highlighted mandatory training modules to the team. The RP arranged a set day for team members to complete their training and look through changes to any policies and new policies. Delivery drivers also completed training on the online portal and had completed safeguarding training. There was a plan to enrol the new team member on a training course provided by Buttercups and give them protected time to complete their training.

The team worked closely together. Any issues team members had or were facing were discussed as they arose or at monthly team meetings. Team members felt able to feedback concerns and give suggestions to the RP. There were no targets set for services provided.

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 gives people information about who is providing its services.

Inspector's evidence

The pharmacy was clean and tidy, and there was ample workspace. Workbenches were allocated for certain tasks with a separate area for checking. Shelves were used for storing part-dispensed prescriptions that were waiting for medicines to arrive from wholesalers. The pharmacy was split across three levels. The ground floor consisted of two separated areas, the front was used for processing prescriptions, dealing with phone calls and deliveries. The back was used to assemble and check prescriptions with minimum distractions. A dispensary on the second floor was used to manage and prepare multi-compartment compliance packs and dispensing medicines for care homes. The consultation room was also on this level. The top floor had a training room and was used to store excess stock. The consultation room was not accessible to people with mobility aids or those who had difficulty climbing up and down stairs. When questioned, the RP said he would signpost people to other pharmacies, including one across the road. But he was looking into having a screened area on the ground floor.

Cleaning was carried out by the team members. Medicines were arranged on shelves in a tidy and organised manner. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access.

The pharmacy had its own online website (https://todmorden-pharmacy.co.uk/). The website gave clear information about the pharmacy's opening times, how people could make a complaint, the pharmacy's contact details and details of its owner and the GPhC registration number of the pharmacy. The pharmacy's website offered a range of over-the-counter medicines, but orders were processed by a different pharmacy, owned by a different owner. People typically used the website to order their repeat prescriptions, this service was also available on an electronic application associated to the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. Team members take the right action in response to drug alerts and recalls. The pharmacy gets its medicines from licensed sources and generally stores them properly. But it does not always remove date-expired medicines from stock in a timely way. So, this may increase the chance that people receive a medicine which is not suitable to use.

Inspector's evidence

The pharmacy premises were closed to the public and people were not allowed to visit the pharmacy in person to collect their medicines. But it had a consultation room on site where it planned to provide face-to-face private services in the future. The pharmacy's services were advertised on its website. Team members were aware of the need to signpost people needing services they could not provide and were aware of services available locally or would use the internet to find more information. There was a step at the entrance and the RP explained that they were waiting to have a ramp fitted, so that the pharmacy was more easily accessible to people using mobility aids and pushchairs.

People were able to register online to have their prescriptions dispensed and delivered by the pharmacy. And when necessary, people were counselled on the use of their medicines via telephone. The pharmacy was also able to communicate with people via video call or email. The website also had information relating to various health conditions if people wanted additional information.

The RP felt the NHS Community Pharmacist Consultation Service (CPCS) had a positive impact on the local population. He described how doctor's surgeries sometimes struggled with appointments, and the service allowed them to make referrals to the pharmacy for an initial consultation. The RP had found in most cases people just needed advice instead of being supplied with a medicine. A follow-up meeting with local surgery had found that the service had been helpful, and the surgery had more appointment availability.

The RP had designed the layout of the pharmacy with the workflow in mind. The dispensary and workflow had been arranged so that the team would not be disturbed by phone calls and incoming wholesaler deliveries. Dispensed medicines were left on dedicated shelves for pharmacists to check and then bagged and sorted for delivery. Part-dispensed prescriptions were left in baskets on the front shelves and completed when delivery from the wholesaler was received. 'Dispensed by' and 'checked by' boxes were available on dispensing labels, and these were routinely used to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing transfer of medicines between different people. Baskets were colour-coded by days of the week that the delivery was due to go out.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The pharmacy's IT system flagged anyone new who had not received sodium valproate before. The RP would call and have a consultation with the person. The team were aware of the labelling requirements and anyone who was in the at-risk group and not part of a PPP was referred to the prescriber. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. Dispensers would highlight these prescriptions to the RP, who would call the person to ensure they were having regular monitoring. Information gathered

during phone calls was not recorded. This could mean that any information collected is not available for future checks.

The RP was an independent prescriber and had issued a few prescriptions for team members. These were mainly for medicines like antihistamines and proton pump inhibitors. The RP said this was not a service that was offered, and he had only issued a few prescriptions. There were no consultation records kept. The RP said he would ensure he did not issue any more prescriptions from the pharmacy and If he did, he would ensure governance arrangements were in place.

Some people's medicines were supplied in multi-compartment compliance packs. Packs were prepared by a dispenser. Individual sheets were available for each person using the service. A record of all their medicines and any changes were updated on the sheets. Assembled packs were labelled with the product descriptions and mandatory warnings. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were issued monthly. Some people's medicines were supplied in electronic devices (Pivitol) and dispensing labels were placed in the dedicated section. On some occasions packs were left unsealed after they had been prepared by the dispensers. The RP agreed that there were risks in storing medicines in this way and provided an assurance that all packs would be sealed in the future.

Care homes ordered prescriptions independently. A list of what was ordered for each person was emailed to the pharmacy and used to check against the prescription when it was received. Changes and missing items were checked with the care home in the first instance. Medicines administration record (MAR) charts were provided to the care homes. The RP held regular meetings with the care homes and visited them at least once a year. Care homes were either supplied medicines in original packs, in multi-compartment compliance packs or on medicine racks. Information about hospital admissions was received via PharmaOutcomes including any discharge information. This was then screened by the pharmacists. Acute prescriptions were highlighted in red and were dispensed and supplied on the same day where possible. Team members monitored new prescriptions received throughout the day. Care homes were not routinely supplied with patient information leaflets unless they requested them. Team members provided an assurance they would be supplied monthly.

The pharmacy's delivery service was provided by a group of four drivers. Each delivery driver kept a record of what they had delivered and to who. Separate slips were used for CDs delivered. In the event that someone was not home, the person was contacted. Some prescriptions were sent via Royal Mail tracked delivery. The pharmacy had a process to deal with returned parcels.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. And CDs were kept securely. Expiry dates were checked routinely, and short-dated stock was marked with stickers. Some date expired medicines were found on the shelves, but all of these had been labelled with short-dated stickers. Expiry dates were checked as part of the dispensing and checking process. When the expired medicines were pointed out a team member was instructed to check and remove all short-dated stock. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received by email, these were printed, shared with the team and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy had a range of clean calibrated measures available. Separate measures were available for liquid CDs to avoid cross contamination. Up-to-date reference sources were available including access to the internet. The pharmacy had three medical grade fridges. The pharmacy had a blood pressure monitor and ear suction machine. The SI planned to make arrangements for calibration when needed. Computers were password protected and screens were not visible to people using the pharmacy. Team members had individual smartcards, and these were not shared.

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.