General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medifix Pharmacy, 601 Bury Road, Bolton, Greater Manchester, BL2 6HZ

Pharmacy reference: 9012064

Type of pharmacy: Internet / distance selling

Date of inspection: 14/12/2023

Pharmacy context

This pharmacy supplies its services at a distance. It is located on a main road in a residential area. The pharmacy dispenses NHS prescriptions which are supplied to people. It supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. And it offers the New Medicine Service (NMS) and a medicine delivery service.

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

The pharmacy generally identifies and manages the risks associated with its services to help make sure the team provides them safely. It keeps the records it needs to keep by law, and these are largely accurate and up to date. 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 available and had been read by the pharmacists who worked at the pharmacy regularly. SOPs covering the Responsible Pharmacist (RP) regulations were not available. Following the inspection, the superintendent pharmacist (SI) confirmed that team members had reviewed and implemented RP SOPs. A risk assessment had been completed by the pharmacy team prior to the registration of the pharmacy. This had highlighted risks associated with different aspects of the business and services, such as data security, prescription security, medication errors, and storage and security of medicines. Steps to mitigate risks were also recorded. The pharmacy had been providing services for less than two months at the time of the inspection. The SI was in the process of updating the risk register.

The RP explained there had not been dispensing mistakes which were identified before the medicine was handed out (near misses) or any mistakes where the wrong medicine was supplied to a person (dispensing errors). When questioned he described that near misses would be recorded on a near miss log and reviewed. Similarly, dispensing errors would be reported on the National Reporting and Learning System (NRLS) so that members of the team could learn from them.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaint 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 but there had been some positive reviews left online. The correct RP notice was displayed.

The pharmacy had not dispensed any private prescriptions, emergency supplies or unlicensed medicines. Records for controlled drug (CD) registers were well maintained. The RP record was generally kept in line with requirements, but pharmacists were not routinely signing out. So, it may be hard to identify when a pharmacist's responsibility had ended. CD balance checks were carried out when medicines were supplied to people. A random check of a CD medicine complied with the balance recorded in the register.

The pharmacy had an information governance policy available, and its team members had completed training about it. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. Pharmacists had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

Pharmacists had completed level three safeguarding training and there was a safeguarding SOP. All team members including the delivery drivers had been asked to read through these. Following the inspection, the SI confirmed he was in the process of enrolling the drivers onto a safeguarding course so they would know how to protect the welfare of vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained staff to manage its workload appropriately. Team members discuss any issues as they arise. And the pharmacy does some planning to assess its future staffing needs.

Inspector's evidence

The pharmacy team comprised of three pharmacists, including the SI. One of the pharmacists only worked on Thursday mornings. There were usually two pharmacists working alongside each other at any given time. The pharmacy also had two delivery drivers who worked alternate days. They were not present during the inspection. The pharmacy were looking to recruit dispensers in the new year. The team were observed working effectively together and were up to date with the workload.

Members of the team did not receive a formal appraisal, but the delivery drivers were provided with ongoing feedback to help improve the service they provided. Prior to joining the pharmacy team, both drivers had worked as pharmacy delivery drivers for over ten years. The pharmacists were unsure of what training the drivers had completed at their previous place of employment. Following the inspection, the SI confirmed that both drivers had read the SOPs relevant to their roles including safeguarding. Pharmacists completed independent training and completed their individual Continuing Professional Development(CPD). Weekly meetings were held with the delivery drivers to raise issues, discuss any problems and discuss ways in which issues can be resolved. There were no targets or incentives in place for any of the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and they are generally clean and secure. The Pharmacy's website gives people information about who is providing its services.

Inspector's evidence

The pharmacy was clean, tidy and organised. The dispensary was small but had sufficient workspace which was allocated for certain tasks to help manage the workload safely. The pharmacy had a room upstairs which had been prepared for additional dispensing tasks as the business grew. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by the pharmacists. The room temperature and lighting were appropriate and the premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for people to have a private conversation.

The pharmacy had an online website (https://www.medifixpharmacy.co.uk/). The website gave clear information about the pharmacy's opening times, how people could complain, the pharmacy's contact details and GPhC registration information and details of the pharmacy owner and SI. The pharmacy did not sell any medicines via its website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible. And it generally 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 safe to supply to people.

Inspector's evidence

People could not visit the pharmacy in person. Services provided were advertised on the pharmacy's website. The pharmacy mainly delivered medicines to people locally. The RP signposted people to other services when necessary. The team had communicated with local GP practices and colleagues from primary and secondary care settings to find information on services available locally to them.

Prescriptions for people were either ordered by the pharmacy or independently by the person requiring the medicines. When the pharmacy ordered the prescriptions, the pharmacist would call people and check which medicines they required. When received, prescriptions were checked against the record of what was ordered to identify any discrepancies. Prescriptions were dispensed by one of the pharmacists and checked by another. The RP explained that he would not self-check his own work and would ask another pharmacist to accuracy check prescriptions that he had dispensed. '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.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). He was aware of the labelling requirements and requirement for sodium valproate to be dispensed in its original packaging where possible. The pharmacy carried out checks on medicines that required ongoing monitoring. However, not many people were supplied these medicines from the pharmacy. Details of any checks carried out were not routinely recorded. This could mean that any information collected is not available for future checks.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. Prescriptions were ordered by the pharmacy. Packs were prepared by one of the pharmacists and checked by another. Assembled packs were labelled with mandatory warnings. Patient information leaflets (PILs) were routinely supplied with the packs but product descriptions of the medicines were not included on the backing sheets. This could make it difficult for people, or their carers, to identify the medicines supplied in the pack. The RP agreed to ensure these were included going forward. Backing sheets were placed loosely within the trays which meant that there was a risk that these could be lost. The pharmacists said they would ensure these were securely attached for all packs.

The pharmacists counselled people over the phone on how to use their medicines. There was no record kept of these conversations. Pharmacists also spoke to people about their medicines when they called to check which medicines needed to be reordered. People could contact the pharmacy via the website or telephone.

The pharmacy's medicine delivery service was provided by the drivers. Delivery records were created by the team which they marked as they completed the delivery of the medicines. Signatures were obtained when CDs were delivered to people. In the event that someone was not home, medicines were returned to the pharmacy. The pharmacy supplied medicines to people who did not live in the local area using a tracked delivery service provided by a third-party courier.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded and were within the required range for the storage of cold chain medicines. And CDs were kept securely. Expiry dates were checked as stock was received from the wholesaler. The pharmacy had a date checking matrix which was signed when the expiry dates of medicines were checked. No date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock. The pharmacy was in the process of arranging a contract for collection of these. Drug recalls were received via email, an electronic folder had been created to store information about alerts once they had been actioned, this helped to create an audit trail to show that the alert had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment in a way to protect people’s private information.

Inspector's evidence

The pharmacy had a calibrated glass measure as well as a plastic measure. Following the inspection, the SI confirmed another calibrated glass measure had been ordered to replace the plastic one. Tablet counting equipment was available. Equipment was clean and ready for use. Up-to-date reference sources were available electronically. The pharmacy's computers were password protected; a cordless phone was available which helped members of the team have a private conversation with people.

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.