General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Precision Pharmacy, Precision House, Lamdin Road, Bury St. Edmunds, Suffolk, IP32 6NU

Pharmacy reference: 9012141

Type of pharmacy: Internet / distance selling

Date of inspection: 25/11/2024

Pharmacy context

This pharmacy is located in an industrial estate in the town of Bury St. Edmunds in Suffolk. The pharmacy dispenses and delivers the Pharmacy only (P) medicines ellaOne, Cialis Together and Hana which people can purchase from the respective websites: www.ellaonedirect.co.uk, www.calistogether.com and www.hana.co.uk. All medicines are delivered to people using third party couriers and the pharmacy is closed to the public.

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 manages the risks associated with its services well. It has risk assessments for the activities that it provides. The pharmacy has appropriate insurance arrangements in place. And it handles people’s private information safely.

Inspector's evidence

The pharmacy’s business involved reviewing and dispatching either ellaOne, Cialis together or Hana that people had ordered from the respective website. Before a purchase could be made people had to complete a questionnaire asking various questions about their background and health. They also had to upload a picture of their ID to be checked by the pharmacy and submit payment for the medicine. Submitted orders were sent to the pharmacy electronically for the pharmacist to view. Depending on a person’s answers to the questionnaire, the order could be approved by the pharmacist immediately or the pharmacy would contact the person for further information before making a decision as to whether a supply was appropriate or not. Examples were seen during the inspection of where the pharmacist had attempted to contact people to get further information on pre-exiting conditions or medication. Orders that were deemed unsuitable or where the pharmacist could not contact the patient for further information were rejected and the person issued a refund.

The team explained that limits were placed on the quantity and number of medicines that could be ordered within a specific timeframe. For Cialis, a maximum of 52 tablets in a six-month period was allowed. If any more were ordered, this would be flagged to be reviewed by the pharmacist who could discuss alternative options with the person. For ellaOne, a maximum of six tablets could be ordered in a 90 day period. However, the SI said that after four orders, any subsequent orders would need a pharmacist review. For the Hana contraceptive pill, people could make a one-off purchase or a three-monthly subscription. For people on a subscription, in order to continue the subscription, the person would need to complete the questionnaire again every three to six months and this would need approval by a pharmacist before subsequent supplies would be made.

The pharmacy had a risk register for each P medicine it was supplying as well as a risk register for the general risks associated with its online service. The risk registers listed the different risks associated with supplying each medicine. Each risk was given a risk score based on the likelihood of it occurring as well as the severity of the risk should it occur. The team explained that test orders were done every month for all three medicines to check that medicines were being appropriately supplied by the pharmacy and that there were no issues with the questionnaire or ordering process. About eight to ten test items were done per month for the three P medicines supplied. The team said that they would look into to completing a full audit of their services in the near future.

The correct responsible pharmacist (RP) notice was displayed in the pharmacy. The RP was also the superintendent pharmacist (SI). There was a range of up-to-date standard operating procedures (SOPs) in the pharmacy which had been read by all team members. Team members were observed working well together during the inspection. And they knew what activities they could and could not do in the absence of an RP. The pharmacy had current indemnity insurance. The RP record was complete with all entries seen having a start and finish time recorded.

Near misses (mistakes which were spotted before a medicine left the pharmacy) were recorded electronically on the person's record. If a medication error (mistake which had reached a person) occurred, an error report would be written, and the team would have a meeting to discuss the error. The SI said that there had not been a medication error at the pharmacy since opening.

There was a customer service team (CST) to deal with complaints. Minor non-clinical complaints and queries were usually resolved by the CST. But any clinical issues were escalated to the RP in the pharmacy or the SI. Confidential waste was disposed of in a separate waste bin when no longer required. The waste was taken away by a third-party company for safe disposal. The SI confirmed that he had completed level two training safeguarding training and knew what to do if he had a safeguarding issue.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. And team members complete the right training for their roles. They do some ongoing training to keep their knowledge and skills up to date. Team members feel comfortable about raising any concerns they have.

Inspector's evidence

The pharmacy team consisted of the SI, who worked occasionally in the pharmacy, three other pharmacists who also worked occasionally in the pharmacy, and two dispensers. The pharmacy had enough team members to manage the workload. All team members had been enrolled on an appropriate training course with an accredited training provider. Team members had been given training and information about the medicines that the pharmacy supplied. And team members had informal meetings with the RP or SI every two weeks to review their progress. Team members felt comfortable about raising any issues and would usually go to the RP on duty first but could also raise a concern with the SI if necessary. The SI confirmed the team was not set any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and provides a safe and appropriate environment for team members to complete their work. And the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The pharmacy area was clean and tidy and had enough floor and desktop space for the team to work safely. The temperature and lighting of the pharmacy were adequate and there was air conditioning and central heating to help control the temperature. The team said the temperature of the pharmacy was recorded regularly and team members would be notified immediately if the temperature of the pharmacy deviated significantly from room temperature. There was a staff toilet with access to hot and cold running water and handwashing facilities located within the same building as well as break room area for team members to use. The pharmacy was kept secure from unauthorised access.

Each of the three websites the pharmacy provided medicines for had a link to the General Pharmaceutical Council's (GPhC) website which had details about the pharmacy. The website for ellaOne had information on the homepage which advised people that emergency contraceptive pills, including ellaOne, had been shown to be more effective the earlier they are taken after intercourse. And that purchasing from a standard pharmacy may be a faster way to obtain ellaOne.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. The pharmacy obtains its medicines from reputable sources and stores them appropriately. And the team takes the right action in response to safety alerts to help ensure people get medicines which are fit for purpose.

Inspector's evidence

The pharmacy was located on the first floor of the building. It was closed to the public. The pharmacy had separate areas for preparing and packaging the medicines to reduce the chance of orders getting mixed up. As part of the packaging process, the pharmacy weighed some packaged orders at random and checked these against a list of confirmed weights of the each of the medicines in the quantities sold to help ensure that the correct product and quantity was being sent to the right person. Medicines were sent in secure and opaque packaging and the pharmacy provided additional leaflets with further information about the medicines. Orders for Hana and Cialis were sent for delivery with Royal Mail using either a 24 or 48 hour tracked delivery service. Orders for ellaOne were only sent by next day tracked delivery using DPD. The team said that there were very few failed deliveries that were returned to the pharmacy. The team said that if this did occur, the medicines would be quarantined, and the person would be contacted to discuss a redelivery. If the order was for ellaOne, a pharmacist would call the person to discuss alternative options.

The pharmacy obtained its medicines directly from the manufacturers. Medicines were stored neatly on the pharmacy shelves with each medicine the pharmacy sold being stored in separate sections which were clearly defined and labelled. Expiry date checks of medicines were checked and recorded when the medicines were first received by the pharmacy and were also checked as part of the packaging process. A random check of medicines on the shelves revealed no expired medicines. Safety alerts and recalls were received electronically via email and also from the manufacturers of the medicines. The action taken for alerts would be recorded and the alert would be archived. The team also recorded the batch number of all orders sent to people in case a recall occurred to make it easier for the team to find out if anyone received a medicine than needed to be recalled.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment to provide its services safely.

Inspector's evidence

The pharmacy computer had access to the internet allowing team members to use any online resources they needed. The computer was password protected. Electrical equipment looked to be in working order and was safety tested earlier in the year as evidenced by stickers on the equipment. There were fire extinguishers located just outside the pharmacy. A team member said they had been serviced earlier in the year. The pharmacy did not dispense any liquids medicines or split packs of medicines.

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.