General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oakwood Pharmacy Online, 1 Roxholme Place, Leeds, West Yorkshire, LS7 4JQ

Pharmacy reference: 9012181

Type of pharmacy: Internet / distance selling

Date of inspection: 26/06/2024

Pharmacy context

This pharmacy is in a suburb of Leeds. People do not visit the pharmacy premises, but they can access its services via its website. And they can contact the team by telephone and email. The pharmacy's main activities are dispensing NHS prescriptions and delivering medicines to people's homes. The pharmacy provides multi-compartment compliance packs to help some people take 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

The pharmacy team members suitably identify and manage the risks associated with the services provided by the pharmacy. They follow written procedures to help them perform tasks safely. And they know how to respond appropriately when errors occur. Team members identify potential risks to the safe dispensing of prescriptions, and they take action to prevent mistakes. The pharmacy protects people's private information correctly, and it mostly completes the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) which provided the team with information to perform tasks supporting the delivery of its services. But there wasn't a date when they would be reviewed to ensure they were still relevant to the services provided. The team had read and signed the SOPs' signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for identifying and recording errors made during the dispensing of a prescription, known as near miss errors. However, no entries had been made in the near miss record. A separate procedure covered errors that were identified after the person received their medicines, known as dispensing incidents. The Superintendent Pharmacist (SI) reported there had not been any near miss errors or dispensing incidents in the six months since the pharmacy opened. And explained the small number of prescriptions dispensed were mostly as repeat prescriptions which were dispensed a week ahead of the person needing their medication. So, the team had time to dispense the prescriptions and focus on dispensing the prescriptions correctly. Team members identified potential risks to the safe dispensing of prescriptions such as medicines that looked alike and sounded alike, which they highlighted to each other. And separated on the shelves to reduce the risk of picking the wrong medication. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And its website provided people with information on how to raise a concern with the pharmacy team.

The pharmacy had current indemnity insurance. A sample of records required by law mostly legal requirements. The Responsible Pharmacist (RP) record was correct as were the controlled drugs (CDs) registers. However, a sample of records of supplies of medicines against private prescriptions found some didn't have the correct prescriber's details. And were missing the date on the prescription. The RP notice was not on display.

The pharmacy's website displayed a privacy notice, details on the confidential data it kept and how it complied with legal requirements. All team members had up-to-date training on handling confidential information. They separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures for the team to follow to help protect vulnerable people. And team members completed safeguarding training relevant to their roles. The delivery driver was a qualified dispenser and used their experience from working at other pharmacies to share any concerns with the SI. So, appropriate action such as contacting the person's GP could be taken.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the appropriate range of experience and skills to provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They have some limited opportunities to complete ongoing training and are supported to take on new roles so they can suitably develop their skills.

Inspector's evidence

The SI worked full-time with occasional support from locum pharmacists. The SI was supported by a full-time dispenser and a part-time dispenser who was also the part-time delivery driver. Team members had limited opportunity to learn and develop with most additional learning linked to regulatory training. Team members received informal feedback on their performance through one-to-one meetings with the SI. The SI had recently discussed with the dispenser the opportunity for them to train to be an accuracy checker.

Team members used a communication platform to share key pieces of information. And when changes were made the SI ensured all team members were aware. For example, the part-time dispenser had implemented a new IT process to help the team efficiently plan its workload for dispensing prescriptions. And had spent time with the SI and the other dispenser to ensure they understood how to use the system.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic, and secure. The pharmacy's website is clearly laid out and professional in appearance which helps ensure people accessing its services receive appropriate care.

Inspector's evidence

The pharmacy team kept the premises clean and tidy. There were separate sinks for the preparation of medicines and hand washing and these were kept clean. Alcohol gel was also available for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. And there was enough storage space for stock, assembled medicines and medical devices. The pharmacy had restricted public access during its opening hours and was kept secure when it was closed.

People accessed the pharmacy's services through its website which was professional in appearance and straightforward to use. People were provided with clear information on how to access the service and could view details of the SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a small range of services that support people's health needs. And it manages its services well to help people receive their medicines safely and receive appropriate care. Team members obtain medicines from reputable sources. And they adequately store and carry out checks to ensure medicines are in good condition and appropriate to supply.

Inspector's evidence

The pharmacy was closed to the public which meant people could not directly enter the pharmacy premises to access its services. Its website provided people with information on the services offered, the contact details of the pharmacy and its opening hours. So, people could communicate with the pharmacy team by telephone and email.

Team members ordered prescriptions on behalf of some people. They kept a list of who they provided this service to along with the dates each month when to order the prescription. A record of the prescription request was maintained so team members could identify missing prescriptions. The SI regularly contacted people to provide advice about their medication for example when they were prescribed new medicines or when there was dose change to their medication. The team asked appropriate questions of people requesting to buy over-the-counter medicines such as paracetamol before they were sent with the delivery driver. The pharmacy supported people who struggled to contact their GP, for example when they had queries about their medication. After receiving a telephone call from people who found themselves in such circumstances the team emailed the surgery to pass on the person’s query. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer’s packs of valproate. And reported that no-one prescribed valproate met the criteria.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. Team members kept a list of people who received the packs and when they were due to be supplied. And they recorded when each stage of ordering the prescriptions and dispensing the medication was completed. Prescriptions were issued as electronic repeat dispensing and dispensing took place several days before supply. Each person had a record listing their current medication and dose times which the team referred to during the dispensing and checking of the prescriptions. To manage the workload and ensure people received their medication on time most packs were dispensed against the medication list in advance of the electronic prescription being released. The pharmacist completed a check of the medicines selected from the shelves to be dispensed into the packs before they were removed from the manufacturer’s packaging. And completed an initial check after the medication was dispensed into the packs. The pharmacist completed a second check once the prescription was received and before the packs were put in bags ready for supply. Team members added the descriptions of what the medicines looked like to the packs but did not always supply the manufacturer’s patient information leaflets. This meant people could identify the medicines in the packs but may not have all the information they need about their medicines. The pharmacy occasionally received copies of hospital discharge summaries via the NHS communication platform. So, the team could check for changes or new items.

The layout of the pharmacy enabled team members to work in different areas when performing tasks such as labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing

process to isolate individual people's medicines and to help prevent them becoming mixed up with others. Pharmacy team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used fridge and CD stickers on bags to remind the team when handing over medication to the delivery driver to include these items. And it stored completed prescriptions awaiting delivery in a dedicated area so the driver knew they were checked and authorised to go. Team members agreed a day and time with people for their regular deliveries. When the person was new to the pharmacy or for one-off deliveries team members contacted the person before the delivery to confirm they would be at home. The pharmacy kept a record of the delivery of medicines to people including a signature from the person receiving the medication. If the person was not at home a note was left informing the person of this and asking them to contact the pharmacy to arrange another delivery. However, most people contacted the pharmacy in advance of the delivery to advise they would not be at home.

The pharmacy obtained medication from several reputable sources. And team members stored the medicines on the dispensary shelves in a tidy manner. However, some plain boxes containing medicines were found that were only labelled with the medicine's name. The batch number and expiry date of the medicine were missing which meant team members would not know if the medication was affected by a safety alert or in date. The SI placed these medicines in the medicine waste bin during the inspection. Team members checked the expiry dates on stock and marked short-dated stock to prompt them to check the medicine was still in date when dispensing. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. They checked and recorded fridge temperatures each day and a sample of completed records found the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication, along with appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Appropriate action was taken in response to the alert and all team members were informed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And a fridge for medicines requiring storage at these temperatures. The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. The pharmacy held other private information securely and had restricted public access.

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.