General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Doncaster Chemist, Office 2, 83 Copley Road, Doncaster, South Yorkshire, DN1 2QP

Pharmacy reference: 9012203

Type of pharmacy: Internet / distance selling

Date of inspection: 07/05/2024

Pharmacy context

This is an NHS pharmacy offering services to people at a distance through its website donchemist.co.uk. People can also contact the pharmacy by telephone. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. It delivers all medicines to people through its delivery services.

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 adequately identifies and manages the risks for the services it provides. It mostly keeps the records it needs to by law up to date. And it keeps people's confidential information secure. The pharmacy advertises how people can feedback. And it uses feedback appropriately to inform how it provides its services. Pharmacy team members have the knowledge and ability to recognise and raise concerns to help safeguard vulnerable people. And they act openly and honestly by sharing learning following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its team members in working safely and effectively. These included an overarching risk assessment of providing pharmacy services at a distance to people. The SOPs did not contain a version number, date of implementation or review date. A discussion with the superintendent pharmacist (SI) highlighted how this would make it more difficult to ensure they were reviewed on a regular basis. Most team members had read the SOPs relevant to their role. But they had not signed to confirm they had done this and to declare they understood them. A team member demonstrated a record of changes they had made together with the SI when initially reading the SOPs to ensure they accurately reflected the pharmacy's processes. And a check of one of these changes about how the pharmacy managed split packs of medicines confirmed the team had completed this action. Team members demonstrated appropriate knowledge for the tasks they were undertaking. They were observed working in accordance with the pharmacy's SOPs and they felt confident in referring queries to a pharmacist.

The pharmacist provided feedback to team members following mistakes found and corrected during the dispensing process, known as near misses. The team had recently started to record these mistakes to support them in identifying trends, share learning, and implement improvement actions following these types of mistakes. Records made contained reflective information, such as clear and honest reasons contributing to a mistake. And they contained action points to support the team in reducing risk. The pharmacy had a process for recording mistakes found after a medicine had been supplied to a person, known as a dispensing incident. The SI stated there had been no incidents reported to date. They demonstrated actions they had taken to learn from feedback provided by people. These actions had included contacting people directly if the team noticed the person's nominated pharmacy had changed to ensure this was an intended change. The pharmacy clearly advertised its feedback processes on its website and within its practice leaflet.

The pharmacy had procedures and information to support its team members in recognising and reporting safeguarding concerns. Pharmacy team members completed safeguarding learning either through their accredited learning course or through separate e-learning. The SI had completed level three safeguarding learning and was knowledgeable about how to raise concerns. Both team members working with the SI provided examples of experiences where they had acted to report concerns to keep people safe from harm. And they understood how to seek support from carers and emergency services should they come across an acute safeguarding concern when providing the pharmacy's delivery service. The pharmacy held all personal identifiable information safely within the premises, and access to the premises was restricted. It segregated its confidential waste and disposed of this waste securely.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. And the sample of the RP record seen was completed in full. The pharmacy kept its CD register in accordance with legal requirements. It undertook regular physical balance checks of stock against its register. The pharmacy had a patient-returned CD destruction register and this was kept up to date. It completed certificates of conformity for the unlicensed medicines it dispensed. And it made appropriate records when dispensing a private prescription. But it had recorded several emergency supplies of medicines as a private prescription in error. A discussion highlighted the correct use of the Prescription Only Medicine register when making an emergency supply of a medicine.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small, committed team of people who work together well. It reviews it staffing levels and the skill mix of its team members as its services change. Pharmacy team members have the confidence to share their ideas and provide feedback at work. And they communicate well with each other and share learning and information through regular conversations.

Inspector's evidence

The SI worked as the regular pharmacist. A regular locum had also worked at the pharmacy since it had opened. The pharmacy reviewed its staffing levels and skill mix at regular intervals, and it had increased its staffing profile as its activity had increased. It currently employed two trainee dispensers, a qualified dispenser, and a delivery driver. It had enrolled one trainee dispenser on a GPhC accredited learning course, the other trainee dispenser and delivery driver were in their induction period. And the SI was aware of the need to enrol them on an accredited course, relevant to their roles within three months of employment. The trainee dispenser discussed a flexible approach to their learning, completing some coursework at work and some at home in their own time.

Team members felt supported in their roles and they had opportunities to provide feedback and drive improvement at work. For example, the dispenser had shared their knowledge and experience when setting up a new system to support the scheduling of work when supplying medicines in multi-compartment compliance packs. The pharmacy had a whistleblowing policy and team members knew how to provide feedback, and where to go for support should they need to escalate feedback outside of the company. The pharmacy did not set specific targets for its team members to meet. There was a focus on working in a timely manner to ensure medicines were ready to be delivered to people. Pharmacy team members engaged in regular discussions about workflow and patient safety. And they used a communications diary to support them in responding to queries and sharing information between shifts.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean and secure against unauthorised access.

Inspector's evidence

The pharmacy was secure and clean. It was maintained to a good standard, with local tradespeople used to manage any maintenance concerns. It was on the ground floor level of a shared business unit. Other health and social care companies operated from the building. The pharmacy premises were relatively organised with working areas free of clutter. But the team was using the pharmacy's consultation room and an area outside the dispensary to store some boxes of sundries and other miscellaneous items. The SI explained the pharmacy was not currently offering face-to-face consultation services and stated they had plans to clear the room, should this change. Lighting throughout the pharmacy was bright and temperature and ventilation arrangements were appropriate. Team members had access to a sink for the reconstitution of liquid medicines, and they had access to separate handwashing facilities. Workspace in the dispensary was good for the level of activity taking place. A team member demonstrated recent improvements to the space for storing stock medicines following the addition of new shelving.

The pharmacy's website included its name, address, registration details and contact information. It clearly displayed the registration details for the pharmacy, the owner, and the SI. And hovering over these details allowed people to click on a link taking them to further details on the GPhC's pharmacy register. The pharmacy did not sell medicines through its website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable suppliers. And overall, it stores its medicines safely. Pharmacy team members make regular checks to help ensure stock medicines remain safe to supply. Pharmacy team members complete effective audit trails when dispensing medicines to support them in responding to queries with confidence. And they provide relevant information to people when supplying medicines.

Inspector's evidence

People accessed the pharmacy's services through its website, by email or by telephone. The pharmacy's website advertised some services including vaccination services and a blood pressure check service, but it was not currently providing these services. The SI explained these were services the pharmacy planned to implement shortly and the ability for people to book a consultation for one of these services was not currently available. The SI shared an example of positive outcomes from the services provided by the pharmacy following a person sharing feedback about the impact of the pharmacy's support on their health and wellbeing.

The pharmacy had effective audit trails to support it in managing its services These included team members signing their dispensing initial within the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy kept records of the deliveries it made to people. A team member demonstrated how they plotted the local delivery route on an application to support the driver in choosing the most efficient route. Delivery records contained important information for the driver, such as alternative arrangements when people were not available to receive their delivery. And the pharmacy obtained consent from people and made relevant checks prior to ensure people's preferred delivery choices were safe for them to follow. The pharmacy used a national tracked delivery service to supply medicines to people outside the locality. The pharmacy kept records of the medicines it owed to people. It informed people by telephone if it was unable to supply a medicine. And it monitored its stock levels to help ensure medicines urgently required by people, such as palliative care medicines, were available.

The team used baskets throughout the dispensing process. This helped to organise workload and reduced the risk of mixing up medicines. The pharmacy identified some medicines as higher-risk, and it required people to sign for these upon delivery. Team members regularly spoke to people via the telephone when managing queries and providing counselling about the safe use of medicines. The pharmacy had tools to support it in supplying valproate to people safely. And the SI was familiar with the requirements of the valproate Pregnancy Prevention Programme (PPP). The pharmacy supplied all valproate in original packs to people and the SI reported it had not received a prescription for a person in the at-risk group to date.

The pharmacy used a schedule to support it in supplying medicines in multi-compartment compliance packs to people. And it used a noticeboard in the dispensary to help monitor the supply of medicines to new people it was providing the service for. Individual records contained some information about changes to people's medicine regimens. But this information was not always supported with details of how the pharmacy had checked and confirmed the change. A team member picked medicines for

assembly into a compliance pack and they completed an audit trail to show they had been involved in the dispensing process. The medicines were then accuracy checked against the prescription by the SI. The team member then de-blistered each medicine and stored this in a small pot, together with the details of the medicine. The SI assembled the compliance packs using the medicines in these pots and they completed the final accuracy check of the medicines against the prescription, patient record and backing sheet. A discussion took place about managing the risk of the current workflow long-term if the pharmacy were to get busier, or during periods when the SI may not be on duty. The pharmacy supplied patient information leaflets routinely when supplying medicines in this way. And it recorded clear descriptions of medicines on the backing sheets supplied with the compliance packs.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. Medicine storage in the dispensary was generally orderly. But some medicines were not stored in the manufacturers original packaging. These were brought to the direct attention of the SI and a discussion highlighted the risks of storing medicines in this way. The pharmacy did not keep records of the checks it made of medicine expiry dates. But team members demonstrated the recent stock checks they had completed by showing how they highlighted medicines with a short expiry date. Random checks of stock medicines found no out-of-date medicines.

The pharmacy stored medicines requiring cold storage in a pharmaceutical fridge equipped with a thermometer. And it kept good records to show the fridge was operating within the temperature range of two and eight degrees Celsius. The pharmacy held its CD stock in a secure cabinet. It clearly identified assembled and checked medicines waiting for delivery to people, and patient-returned medicines in the cabinet. The SI stated they had recently ordered some CD denaturing kits to support the timely destruction of these patient returns. Waste receptacles for other medicine were readily available to the team. The SI received details of drug alerts and recalls by email to their personal account. And they had acted to share and make checks of the alerts they had received to date since the pharmacy had opened. A discussion highlighted the need to ensure these alerts could be accessed by the pharmacy team should the SI take leave.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to provide its services. Its team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources. They accessed the internet to help resolve queries and to obtain up-to-date information. They used password-protected computers and their personal NHS smart cards when accessing people's medicine records. The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. This equipment included standardised glass measuring cylinders in varying sizes and tablet counters. Personal protective equipment such as disposable gloves were available for team members to use. The pharmacy's blood pressure monitor was from a reputable manufacturer and various size cuffs were readily available for use with the machine.

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.