General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Online Delivery Chemist, Unit 6A, Ransom Hall, Ransom Wood Business Park, Southwell Road West, Mansfield, Nottinghamshire, NG21 0HJ

Pharmacy reference: 9012225

Type of pharmacy: Internet / distance selling

Date of inspection: 18/06/2024

Pharmacy context

This is an NHS pharmacy offering services to people at a distance through its website onlinedeliverychemist.co.uk. People can also contact the pharmacy by telephone. The pharmacy's main activity is dispensing NHS prescriptions. It also offers a free video consultation service for people requiring advice and support with common health conditions. 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 service.

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 appropriately identifies and manages the risks for the services it provides. It regularly seeks feedback from people using its services and it uses this feedback to inform how it provides them. The pharmacy holds confidential information securely and it mostly keeps the records it needs to by law. Pharmacy team members understand how to recognise and report concerns about potentially vulnerable people to help keep them safe from harm. And they act openly and honestly by discussing the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management and dispensing processes. They also included an overarching risk assessment of providing pharmacy services at a distance to people. The pharmacy kept training records showing its team members had read and understood the SOPs. Pharmacy team members were knowledgeable about the tasks they were undertaking, and they felt confident in referring queries to the superintendent pharmacist (SI).

The pharmacy team demonstrated how it applied learning and acted to reduce risk following mistakes found and corrected during the dispensing process, known as near misses. These actions included removing medicines from their original storage location in the dispensary and isolating them in clearly labelled baskets to help reduce picking errors during the dispensing process. But the team had not recorded these mistakes to help it identify trends and to support it in measuring the success of its risk reduction actions. 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 discussed how they would respond to a dispensing incident including the need to report the incident using a national template. The team demonstrated how they had shared learning about known risks and had used this to inform stock placement in the dispensary to help reduce the risk of similar looking medicines and those with similar names from being stored together.

The pharmacy had a complaints procedure, this was clearly advertised on its website. The pharmacy promoted feedback when delivering medicines to people. It did this through including a quick response (QR) code on team members identification badges. Team members invited people to scan the badge with their mobile phone when delivering their medicines. This opened a link to a popular web-based review site. The pharmacy regularly read and responded to the reviews it received, all of which had been positive to date. A team member demonstrated how the team had used feedback to inform how the pharmacy provided its medicine delivery service. For example, it now printed people’s telephone numbers on bag labels and called people if they were any problems in making a delivery.

The pharmacy had a safeguarding procedure and its team members understood how to recognise and report safeguarding concerns. The SI had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education. Other pharmacy team members had engaged in discussions about safeguarding and how it applied to their role when providing pharmacy services at a distance. They provided examples of exploring how the pharmacy could support people in taking their medicines safely. For example, by considering whether supplying medicines in a multi-compartment compliance

pack would be beneficial for a person. The pharmacy held all personal identifiable information within the premises and access to the premises was restricted. It disposed of its confidential waste securely.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. And the RP record was completed as required. The pharmacy held an electronic private prescription register but it did not always record the date the prescription was written accurately in the register when dispensing private prescriptions. The SI acknowledged this as a learning point for the team. The pharmacy kept its CD register in accordance with legal requirements. It kept running balances in the register, but it did not undertake full balance checks of physical stock against the register. This meant it may be more difficult for the pharmacy to investigate a balance discrepancy should one occur. Random checks of physical stock carried out during the inspection matched the balances recorded in the CD register. The pharmacy had a register to record its patient-returned CDs, but it recorded returns in the register at the point of destruction and not upon receipt. A discussion highlighted the need to record patient-returned CDs at the point of receipt to ensure there was a full record of all CDs held on the premises. The SI acted on this feedback immediately by entering the current returns in the register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy regularly reviews its staffing levels and skill mix to ensure they remain appropriate. Its team members work together well. They feel confident in providing feedback at work to help drive improvement. And they engage in some continual learning to support the safe delivery of pharmacy services.

Inspector's evidence

The SI worked as the regular pharmacist with a trainee dispenser and a part-time delivery driver. The pharmacy employed locum pharmacists to cover the SI's leave. The SI demonstrated how they had kept staffing levels under review and had recently increased the driver's hours in response to an increase in activity. The pharmacy did not set specific targets for its team members to achieve, the current focus was on growing the business. The team provided examples of how they did this through leaflet drops and by providing a personal approach when speaking to people. The trainee dispenser had worked on and off at the pharmacy since it had opened around seven months ago. They had completed in-house learning and were competent in demonstrating how they followed the pharmacy's SOPs and worked safely when completing tasks. But they had not been enrolled onto an accredited GPhC learning course to support them in their role as required. A discussion highlighted the GPhC's training requirements for pharmacy support staff, and the acceptable length of an induction period. The SI provided evidence of enrolment on accredited training courses shortly after the inspection took place.

The pharmacy had a whistleblowing policy and team members knew how to raise a concern at work. They felt supported in their roles and were confident in providing feedback to help drive improvement. For example, the trainee dispenser had developed a daily checklist of safety checks and record keeping tasks requiring completion. This helped the team to keep up to date with key governance tasks such as checking and recording fridge temperatures and completing pharmacy records. Pharmacy team members engaged in regular discussions on topics such as patient safety and processes to support team members in providing the pharmacy's services safely. The team demonstrated how they acted to reduce risk following these discussions. For example, by separating medicines with similar names on the dispensary shelves to help prevent a picking error.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and properly maintained. Its premises offer a suitable environment for providing healthcare services.

Inspector's evidence

The pharmacy was a single unit on the ground-floor a business centre. The reception desk of the business centre was staffed during working hours, and all visitors were required to sign-in at the reception desk. The pharmacy was maintained to a good standard, there was a process for reporting any maintenance concerns to the business centre team who had a dedicated maintenance department. The pharmacy was secure, organised, and clean. It consisted of a dispensary and a consultation room. Work bench space in the dispensary was sufficient for the level of activity taking place, there was separate space assigned for labelling, assembly and checking tasks. Lighting throughout the pharmacy was bright with a large amount of natural light coming into the room. Temperature and ventilation arrangements were appropriate. Team members used the business centre's shared toilet facilities for hand washing and kitchen facilities for access to fresh water. There was a portable sink in the dispensary, but this was not in active day-to-day use.

The pharmacy's website displayed the GPhC voluntary internet pharmacy logo, clicking the logo took people to the pharmacy's information on the GPhC register. This helped to provide assurance to people visiting the website that it was a genuine registered pharmacy website. Other information on the website included the pharmacy's name, address, details of the pharmacy's owner and information about how to check the registration details for the pharmacy and the SI. The pharmacy did not sell medicines through its website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are clearly advertised through its website and are accessible to people. It obtains its medicines from reputable suppliers. And it stores its medicines safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply to people. And they provide people with relevant information when supplying medicines to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy's services through its website, by email or by telephone. The pharmacy's website provided people with accurate and helpful information about its services, including a video consultation service. People could book a 15-minute free video consultation with the pharmacist through the website. This was intended to support people with advice about common ailments such as coughs and colds, aches and pains and seasonal allergies. And may lead to the sale of a General Sales List or Pharmacy-only medicine. The SI described how they had provided guidance on selfcare to people using this service. The SI also regularly spoke to people on the telephone about their medicines. And the team provided examples of how it had supported people with queries about their medicines by taking the time to talk to them. The pharmacy also contacted people if their medicine was not currently in stock to help establish when the medicine was required. This also acted to inform people of the need to contact their prescriber should the pharmacy be unable to obtain the medicine due to wider supply problems outside of the pharmacy's control.

The pharmacy asked people to sign for the delivery of their medicines. And the pharmacy obtained consent from people and made relevant checks prior to delivery to ensure people's preferred delivery choices were safe for it to follow. The pharmacy had a process to manage failed deliveries which saw medicines returned to the pharmacy. The team explained it had not needed to use a national delivery service to date. But it had considered which services were available if a person outside of the locality nominated the pharmacy to dispense their prescription. The SI provided assurances that only a tracked delivery service would be used to deliver medicines.

The SI explained that they would contact people if they noted a need to provide counselling when supplying a medicine. The team discussed the checks they made with people to ensure they understood how to take their medicines. And the SI provided examples of how they had personally delivered medicines when they felt there was a benefit for a person to have a face-to-face conversation with a pharmacist. They were aware of most of the requirements of the valproate Pregnancy Prevention Programme (PPP). But they were not aware of the need to formally document a risk assessment if they did not supply valproate within the manufacturer's original packaging. The SI provided assurances of a review taking place to support the pharmacy in fully complying with the requirements immediately after the inspection.

The pharmacy kept audit trails of the prescriptions it ordered on behalf of people to help it manage queries and follow up on any missing prescriptions. Team members used baskets throughout the dispensing process. This helped to organise workload and reduced the risk of mixing up medicines. They generally completed audit trails when dispensing medicines by signing their initials in the 'dispensed by'

and ‘checked by’ boxes on medicine labels. But some assembled multi-compartment compliance packs had not been signed to show who had assembled them. This meant it may be difficult for the pharmacy to manage a query arising following the supply of the compliance packs. The team used the patient medication record (PMR) system to support it in supplying medicines in multi-compartment compliance packs. It labelled compliance packs with clear information about the medicines they contained, and it routinely provided patient information leaflets when supplying medicines in this way. The pharmacy dispensed some medicines to people living in care homes. It had effective processes for managing this service and for identifying interim medicines requiring urgent delivery. It had created personalised delivery records to support care home teams in safely checking-in the medicines it delivered to them. And it supplied medication administration record (MAR) sheets to support care home teams in administering medicines to people safely.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage in the dispensary was neat and orderly with medicines stored in the manufacturer’s original packaging. The team carried out regular checks of the pharmacy’s stock medicines. And it kept a record of the checks it made of medicine expiry dates. It annotated open bottles of liquid medicines with details of the date the bottle was opened. This prompted checks to ensure the liquid medicine remained safe to supply to people. Random checks of stock medicines found no out-of-date medicines. The pharmacy stored medicines requiring cold storage in a pharmaceutical grade fridge equipped with a thermometer. And it kept 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 pharmacy had a supply of CD denaturing kits and medicine waste containers. And team members understood how to dispose of patient returned and date-expired medicines safely. The pharmacy received details of drug recalls and alerts by email. Team members discussed how they acted on these alerts by making relevant checks of stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Pharmacy team members had access to a range of digital pharmacy reference resources. They accessed the internet to help resolve queries and to obtain up-to-date information. They used password-protected computers and 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 for liquid medicines and tablet triangles for counting tablets. A laptop computer and a high-quality camera were available to support the video consultation service. The pharmacy had purchased its pharmaceutical fridge second-hand. It had arranged for an external company to check the fridge prior to its first use to ensure it was in safe working order.

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.