General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Live Well Nationwide, Unit 4, Crabtree Close, Fenton Industrial Estate, Stoke-on-Trent, Staffordshire, ST4 2SW

Pharmacy reference: 9012253

Type of pharmacy: Internet / distance selling

Date of inspection: 08/05/2024

Pharmacy context

This is a distance selling pharmacy located in an industrial estate in Stoke. People cannot usually visit the pharmacy in person, and it provides its services remotely. It mainly supplies medicines to people that live in their own homes but also supplies some medicines to people residing in care homes. And the pharmacy offers some NHS services such as the New Medicine Service and Discharge Medicine Service. The pharmacy also sells a limited range of medicines through its website https://livewellnationwide.co.uk/.

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 has written procedures to help make sure team members provide its services safely and effectively. And it keeps the records it needs to by law. It makes records of mistakes that happen during the dispensing process, but it doesn't regularly review these so that its team members can continue to learn from them. Members of the pharmacy team effectively keep people's private information safe, and they know how to safeguard people that may be vulnerable.

Inspector's evidence

The pharmacy had Standard Operating Procedures (SOPs) which covered all the services that were being provided. Some SOPs had been reviewed in August 2023 as the pharmacy prepared to move premises. Electronic training records were available to show all team members had read the SOPs that were relevant to their role. Members of the team knew their role for the day and what workload needed to be completed. But they were unsure of the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. The SI explained that there always two pharmacists present, so it was unlikely that an RP would be absent. However, they would brief the team about the activities they can complete whilst the RP was absent. The pharmacy had professional indemnity insurance in place.

The pharmacy had a process to support the team with learning from mistakes that were identified during the final check by the accuracy checker, also known as near misses. The team member completing the accuracy check would ask the team member involved in the dispensing process, to identify the mistake and correct it. The error was then logged on an electronic near miss record by the dispenser. The pharmacy did not routinely review the near misses each month which meant its team members may miss out on some learning opportunities and common mistakes may not always be identified. Any mistakes identified after medicines had been handed out (dispensing errors) were recorded and filed securely; these were discussed with the team members to help reduce the risk of similar mistakes happening again.

The pharmacy's RP record and private prescription register were completed in line with requirements. Electronic controlled drug (CD) registers had been filled in correctly and running balances were maintained. CD balance checks were carried out frequently. Running balances for three CDs were checked and matched the physical quantities that were being held in the cabinet. CDs that were returned to the pharmacy were recorded in an electronic patient returns register and the entries were marked when the medicines were destroyed.

The pharmacy had a process for managing complaints and the team were aware of the steps to follow if a complaint needed to be escalated. The complaints process was also displayed on the pharmacy website for people to see. In the first instance, team members would try to resolve a complaint verbally but would refer to the SI if it required escalation. The pharmacy had a confidentiality policy which all team members had read. When questioned, members of the team described the ways in which they protected people's private information. For example, they used a shredder to destroy confidential waste. Members of the pharmacy team were aware of the pharmacy's safeguarding procedures and what to do if they have any concerns to support the wellbeing of anyone vulnerable. Details of the local safeguarding contacts were easily accessible. Both of the regular pharmacists had completed formal

safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. It provides support to members of the team who are completing training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy team consisted of two regular pharmacists, one of which was the SI, two qualified dispensers, one trainee dispenser and two delivery drivers. The SI worked at the pharmacy every day and was responsible for overseeing the operations of the pharmacy and the management of its team members. The trainee dispenser had only just been enrolled on to a suitable dispensing course following their recent employment and they felt well supported by other team members.

Team members were seen managing the workload safely and they communicated well with each other when processing prescriptions. They received an annual appraisal to discuss how they had performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the management team. As the team was small, meetings were held when required to discuss pharmacy related topics and if any support was required. They also discussed near misses and errors to help improve the safety of the services they provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are clean and generally tidy. A consultation room is available so the team can have private conversations with people.

Inspector's evidence

The pharmacy was large, clean, and well-lit which made it suitable to supply medicines in an effective manner. There was enough workspace for its team members to assemble medicines but some of the workbenches were cluttered which could increase the chance of a mistake happening. The pharmacy was cleaned by members of the team at the end of each day. However, some areas of the pharmacy were untidy which may detract from a professional environment and the floor near to the shredder was littered with paper.

A clean and tidy separate room was mainly used for storage. People did not attend the pharmacy the receive a service, but the room was suitable for people to have a private conversation if needed. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy was secured when closed.

The pharmacy had a website, https://livewellnationwide.co.uk, which detailed the address and registration details of the pharmacy. It also displayed the registration details of the SI. The pharmacy sold over-the-counter medicines and a limited range of pharmacy only medicines (P-Meds) via its website. Some higher risk medicines liable to misuse were available online but couldn’t be purchased following the SI’s decision not to sell them.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides the services it offers in a safe and effective manner. But it doesn't always maintain a record of the questions it asks people when selling over-the-counter medicines via its website. So, it may not always be able to demonstrate that supplies are made safely. The pharmacy gets its medicines and devices from appropriate sources. And pharmacy team members take appropriate action if medicines or devices are not safe for people to use.

Inspector's evidence

The pharmacy was offering its services at a distance as it was not open for people to visit in person. It had a website which encouraged people to sign up online so that their NHS prescriptions could be sent directly from their doctor to the pharmacy and then delivered to them. And they sold some medicines online. The pharmacy mainly supplied medicines to people that lived in their own homes, but it also supplied medicines to two small care homes.

The pharmacy received prescriptions electronically. These were clinically checked by the pharmacist before being processed for assembly. Once the clinical check was complete, the prescription was processed by a dispenser. They generated a picking list which allowed them to see which medicines needed to be dispensed from the shelves. They then scanned a 2D barcode on the medicine packaging to generate a dispensing label. This helped to make sure that the correct medicine had been dispensed. If all was correct, a label was generated and attached to the medicine box. If there was a mismatch between the dispensed medicine and the prescription, a warning box would appear on the computer to prompt the team member to double check the medicine. Members of the team explained that this had helped reduce the number of near misses considerably. Medicines that required an accuracy check pharmacist were put into a basket and placed on a dedicated shelf. The pharmacy computer system also completed some of the accuracy checks if the prescriptions and medicines were all scanned in properly. Any prescriptions that were manually changed by a member of the team, for example a change in dosage instructions from the details on the prescription, required an accuracy check by a pharmacist. Baskets were used to separate people's prescriptions and different coloured trays were used to help prioritise the workload. Each dispensing label had a 2D barcode printed on it and when scanned it showed who was involved in the dispensing and checking process. This meant that the pharmacy could easily identify which members of the team were involved in the assembly of a prescription if a dispensing mistake was to occur.

The pharmacy supplied some medicines in multi-compartment compliance packs to people to help them take their medicines correctly. An electronic record was maintained for each person receiving a compliance pack which detailed the medicines they were using. This allowed team members to identify any discrepancies when new prescriptions were issued. Any changes to medicines were recorded electronically to create an audit trail. If a person was discharged from hospital, a record of the discharge summary was retained in the event of a query. The packs were labelled with medicine descriptions so that people could easily identify their medicines. And patient information leaflets were supplied so that they could access additional information if needed.

The pharmacy delivered medicines to people's homes or directly to the care homes. It used both employed delivery drivers for local deliveries and a courier for nationwide deliveries. The pharmacy delivery drivers used an electronic system to log the deliveries which maintained a record of the

medicines that had been delivered. A signature was required when medicines were delivered to people. This helped to create an audit trail if a query arose following the delivery of a medicine. Medicines that were sent with a courier, were on a tracked service which allowed team members to see where the delivery was when in transit. Cold chain medicines were sent in suitable packaging to help make sure that the medicines were stored at the correct temperature when being delivered.

The pharmacy had a process in place to provide additional advice to people who were supplied with higher-risk medicines. The pharmacy team marked any prescriptions that required the pharmacist to provide extra information to help make sure the medicine was safe to use and they called the person before the medicine was delivered to provide extra advice. But a record of this was not made which meant it may affect the continuity of care. The pharmacist was aware of the additional counselling required by the Pregnancy Prevention Programme with sodium valproate products and the steps to take for people in the at risk-group. This also included providing valproate containing medicines in its original container so that the patient warning card and patient information leaflet were provided with each supply.

Some over-the-counter medicines and P-Meds were sold on the pharmacy website. People were required to register an account to place an order for any medicines. Once an order was placed, the pharmacy team reviewed the order, and the pharmacist contacted the person to ask them relevant questions to help make sure they supply of the medicine was safe. But no record of this which would make it difficult to respond to any queries or concerns. Some medicines had a questionnaire assigned to it and people completed this before placing an order. The SI explained limits were set on how many packs of each medicine could be purchased and any orders exceeding this limit were cancelled. Some examples of this were shown but the reason for the cancellation wasn't always recorded.

A process was in place to check the purchase history when people placed an order to help make sure multiple orders of similar medicines were not being processed within a short time frame. The SI explained that following a risk assessment being completed, they did not sell any higher-risk medicines that be liable to abuse. Some of these higher-risk medicines were still being displayed on the website but people were unable to purchase them.

The identity of people placing an order was not being verified which meant there was a risk of medicines not being supplied to the intended user or not being safe. The risks of this were discussed and the SI provided subsequent evidence that identify verification was being completed going forwards. The verification process checked the person's details against a passport or driving license and had the ability to compare it to a current picture of the person placing an order. Sales of medicines were age restricted.

The pharmacy used a range of licensed wholesalers and medicines were stored appropriately in the original packs. Access to prescription medicines was restricted. The expiry dates of medicines were checked every three months by members of the team and a record of the checks was maintained. A selection of medicines stored on the shelves were checked, and none were found to be out of date. The pharmacy had a suitable fridge available, which was within the appropriate temperature range for medicines that required cold storage. A daily record of the fridge temperature was stored electronically. The pharmacy had a secure CD cabinet available to use. CDs that had been returned to the pharmacy were clearly marked and separated from stock CDs. The pharmacy received alerts regarding defective medicines by email. Its team members checked the pharmacy for any affected stock and an electronic record was kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. There was a pharmaceutical fridge in the dispensary. Members of the team had access to electronic resources such as the British National Formulary (BNF) and Drug tariff. This meant the pharmacy team could refer to the most recent guidance and information on medicines. Electrical equipment looked to be in good working order. Access to people's electronic data on the pharmacy's computers were password protected.

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.