General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: TOP Pharmacy, Highfield, Waterloo Road, Hadley Hollow, Telford, Shropshire, TF1 5NX

Pharmacy reference: 9012325

Type of pharmacy: Internet / distance selling

Date of inspection: 11/09/2024

Pharmacy context

This is a distance selling pharmacy located in Telford, Shropshire. The pharmacy recently opened in March 2024. People cannot usually visit the pharmacy in person, and it provides its services remotely. It mainly supplies medicines to people that are in care homes but also supplies medicines to a small number of people living in their own home. The pharmacy has a website (https://toppharmacy.co.uk/) which people can access for information and health related services. And it offers some limited NHS services such as the Pharmacy First Service, Discharge Medicine Service and New Medicine Service

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 which are designed to help make sure team members provide its services safely and effectively. But some procedures do not always reflect the way certain tasks are being completed. This may mean members of the team do not have accurate written instructions to refer to in the event of a query or incident. The pharmacy keeps the records it needs to by law. And it makes records of mistakes that happen during the dispensing process so that its team members can learn from them. Members of the pharmacy team effectively keep people's private information safe and take the correct action to safeguard people that may be vulnerable.

Inspector's evidence

The pharmacy had assessed the risks of the services it provided at a distance and written risk assessments were available. Mitigating factors had been included to demonstrate the actions that had been taken to try and reduce the level of risk. For example, it had identified the risk of identity fraud via its website. And it had recorded the use of identity verification software to reduce this risk. The pharmacy was not selling any medicines via its website at the time of inspection, and it was not actively marketing its services to people. A pharmacist-led prescribing service was advertised on the pharmacy's website (https://toppharmacy.co.uk/) but the superintendent pharmacist (SI) explained that the service wasn't being provided.

The main activity was the supply of medicines to people who were residing in care homes in the local area. Team members routinely signed dispensing labels to create an audit trail of who was involved in the dispensing and accuracy checking process. A record of mistakes that had been identified as part of the final accuracy check, also known as near misses, was maintained. Three written near miss records were seen with details of the mistake and the action taken to try and reduce the chance of similar mistakes happening again. The SI explained that the error rate was low as team members were able to work without distractions. And the volume of dispensing was low which allowed adequate time to assemble prescriptions. There was a process in place to record and investigate dispensing errors which is when a mistake is identified after the medicine has been supplied to the person.

Written procedures were in place which covered the services that were offered. Most team members had signed a training matrix to demonstrate they had read and accepted the standard operating procedures (SOPs). However, the delivery driver had not so they may not be able to show that they fully understand the processes that underpin the tasks they complete. The pharmacy had an agreement with a local GP practice so that people could collect their dispensed medicines from the practice site. A standard operating procedure (SOP) was available for this arrangement, but it did not accurately reflect the process that team members were carrying out. For example, the procedure contained incorrect terminology and referred to a post office rather than a GP practice. There was no mention of controlled drugs (CDs) or fridge items and how these medicines should be correctly handled. This meant there was a risk of team members not being able to refer to an accurate SOP in the event of a query or adverse event. The SI agreed to update the SOP and subsequently provided an updated copy. It included arrangements about the safe acceptance and storage of CDs and medicines that require refrigeration. The SI also explained that the team members working in the GP practice had received some training about the supply of CDs and the requirement to as for a suitable form of identification.

A complaints procedure was available and was clearly advertised on the pharmacy's website. The SI met with care home staff on a regular basis to discuss any issues and receive any feedback on how the service provided could be improved. A correct responsible pharmacist (RP) notice was displayed, and team members correctly explained the tasks that could and could not be completed if the RP was absent. A certificate confirming professional indemnity insurance was seen.

CD registers and RP records were kept and maintained in line with requirements. The physical balance of two CDs were checked against the running balance and found to be correct. Records for the supply of unlicensed medicines were largely kept accurate but a couple of records did not state the details of the prescriber. This was required to demonstrate who provided the authority to supply the medicine. The SI agreed to ensure this information was recorded going forwards. The pharmacy had not supplied any medicines against private prescriptions.

An SOP about information governance was available and team members had confidentiality agreements as part of their employment contracts. Team members explained some of the steps they took to protect people's private information such as identifying confidential waste and shredding it. And computers were password protected. Team members explained that they would refer to the RP to seek advice if they had any safeguarding concerns. The regular pharmacist had completed level three safeguarding training and was able to access details of the safeguarding leads.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to safely provide its services. It enrols members of the team on to suitable training courses so that they develop the correct skills and knowledge for their roles. And it supports them to complete the learning to aid their development. Members of the team feel comfortable to raise concerns and can provide feedback.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was also the SI, two trainee dispensing assistants and a delivery driver. The trainee dispensing assistants had been enrolled on to a suitable training course for their role with a recognised provider. When questioned, both trainees felt well supported and were given time to complete their learning. They explained that the pharmacist was available to help with any training needs or queries. However, the delivery driver had not completed any formal training for their role and had not been enrolled on to a course. The SI subsequently sent confirmation that the driver had been signed up to a training course with a recognised provider.

Team members were seen managing the workload safely and they communicated well with each other when processing prescriptions. The pharmacist worked closely with the trainees and supervised the tasks they completed. They also delegated tasks to members of the team each day. This helped to make sure that the workload was completed in a safe and timely manner. Locum pharmacists were used to cover when the regular pharmacist was absent. And a locum pharmacy technician, who was also trained to complete accuracy checks, was used when additional support was needed.

The pharmacy had opened in March 2024, so team members were yet to receive an annual appraisal. The SI explained that the planned to complete these and discuss performance issues, future progression plans and any development opportunities. Informal team meetings were held at most lunchtimes and the team used this as a chance to raise any concerns, provide feedback or discuss any mistakes that had been identified. They also discussed workload plans. There were no targets or incentives in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are large and suitable for the level of workload undertaken and it is kept clean and tidy.

Inspector's evidence

The pharmacy was situated within a premises which was previously a GP practice. There were several rooms which were allocated to different parts of the dispensing process to help establish a workflow that suited members of the team. There was enough organised workspace for its team members to assemble medicines safely. The pharmacy was cleaned by members of the team at the end of each day. A clean sink was available and suitable for the preparation of medicines. A small staff kitchen and WC was available, and both were clean and tidy.

The pharmacy had a website, https://toppharmacy.co.uk/, which detailed the address and registration details of the pharmacy. It also displayed the registration details of the SI. The pharmacy did not sell any medicines via its website at the time of inspection, and it was not offering any of the prescribing services that were advertised on the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides the services it offers in a safe manner. It 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. Members of the team give advice to people when supplying higher-risk medicines to help make sure they are being used safely.

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 them to sign up online so that their NHS prescriptions could be sent directly from their doctor to the pharmacy and then delivered to them. The pharmacy mainly supplied medicines to people that resided in care homes.

All medicines that the pharmacy supplied to people were in original packs. Medication administration record (MAR) charts were supplied to care homes to help keep track of the medicines that had been supplied to residents. Care homes were responsible for ordering the medicines that were required. And they sent a copy of any order requests to the pharmacy. Team members at the pharmacy checked the requests against new prescriptions to help make sure it was correct and present. Any missing prescriptions were queried with the GP practice. And changes to treatments were recorded on the patient medication record system.

Team members signed the dispensing labels to show who was involved in the dispensing and accuracy checking process. Baskets were used to separate individual people's prescriptions to avoid them being mixed up. Prescriptions that included a fridge item or CD were clearly marked to act as a prompt. And the expiry date of CD prescriptions was noted to avoid them being delivered after this date. The pharmacist was aware of the updated guidance regarding valproate and topiramate containing medicines. Other higher risk medicines were identified during the accuracy checking process and the pharmacist explained they contacted people in advance of it being delivered to them to confirm any blood tests and counselling advice help make sure they remained safe to use.

The pharmacy delivered medicines to people's homes or directly to the care homes situated in local areas. Deliveries were completed by a driver or the pharmacist, but an audit trail was not kept which meant it may make it harder for the pharmacy to respond to a query following the delivery of a medicine. Some medicines were delivered by courier using a tracked service. A record of these deliveries was maintained. The pharmacy had an agreement with a local GP practice to act as a prescription collection point. Dispensed medicines were delivered to the GP practice for people to collect if consent was provided. A record of the deliveries was maintained. The prescription was retained at the pharmacy and were reconciled against the record. Any medicines that had not been collected within four weeks were returned to the pharmacy. Training about the handout procedure had been provided to staff working at the GP practice.

The pharmacy offered a few NHS commissioned services such as Pharmacy First, Discharge Medicine service and New Medicine service. The uptake of these services was low and in some cases the pharmacy had not received any referrals. However, the pharmacist had completed the relevant training and had patient group directions available to deliver the service when required.

The pharmacy used 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. But they did not make a record of completed checks so it may make it harder to identify which areas of the pharmacy have been checked and by who. A selection of medicines stored on the shelves were checked, and none were found to be out of date. And liquid medicines had a date of opening written on them.

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 temperatures was maintained. It also kept a record of the of temperatures of the fridge used to store medicines at the GP practice acting as a collection point was also kept so that it could demonstrate refrigerated medicines were being stored appropriately. 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 a record of the actions taken were 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 fridge in the dispensary which was suitable for the storage of cold chain medicines. 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 was new and looked to be in good working order. It was last tested in June 2024. 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.