General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Target Pharmacy, Orbital House, 3 Redwood Crescent, East Kilbride, Glasgow, South Lanarkshire, G74 5PA

Pharmacy reference: 9012393

Type of pharmacy: Internet / distance selling

Date of inspection: 03/10/2024

Pharmacy context

This is small internet-based pharmacy associated with a larger wholesaler in a business park in East Kilbride. It provides specialist dispensing services for a limited range of medicines which include for aesthetics, unlicensed medicines known as “specials” and medicines to treat attention deficit hyperactivity disorder (ADHD). It dispenses a small volume of prescriptions each month. People do not attend the pharmacy to collect their medicines, instead the pharmacy arranges delivery.

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 monitors the safety and quality of its services. Team members record errors made during the dispensing process and discuss them with the pharmacist to help their learning. They keep the records required by law. And they keep people's private information safe. They have procedures to follow if they have a concern about the welfare of vulnerable adults and children. The pharmacy's written procedures help team members to manage risk and deliver services safely. And risk assessments help identify some risks, but the pharmacy could do more to mitigate some of the risks with its services.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) which had been reviewed in April 2024. The SOPs were version controlled and documented changes made to the SOPs when reviewed by the superintendent (SI) pharmacist. They included SOPs about the responsible pharmacist (RP), delivery of medicines and supply of cannabis-based products for medicinal use (CBPMs). Team members signed a log confirming they had read them. Records showing that two team members had read the updated SOPs could not be found during the inspection, but previous versions had been read. The pharmacy's most recently employed team member had read the up-to-date SOPs and signed the training log.

The pharmacy had completed risk assessments (RAs) which were used in conjunction with the SOPs to help mitigate the risks of providing the pharmacy's services. These included risk assessments about supplying unlicensed controlled drugs and the supply of non-surgical aesthetic products on prescription. These risk assessments had been introduced in response to the last inspection. The pharmacy had also begun dispensing medication to treat ADHD including controlled drugs (CDs) and had completed a RA for this service. The pharmacy's risk assessments identified some risks associated with providing the services but for example, it did not identify risks about some specific products, including botulinum toxins. And it did not have individual risk assessments for the medication it supplied against ADHD prescriptions. The pharmacy was due to complete a review of its RAs in line with the SOP review which was schedule to take place in April 2026.

The pharmacy had a RA for when the pharmacy began working with a new clinic. The RA included making checks to ensure that the clinic was registered with the appropriate regulator, for example the Care Quality Commission (CQC) or Health Improvement Scotland (HIS). Team members completed monthly verification checks on the prescribers they received prescriptions from. And through these checks, they had identified one prescriber who was no longer registered with the General Medical Council (GMC) and had made sure no prescriptions were dispensed from the prescriber. For prescribers who issued prescriptions for CBPMs, team members checked that they were registered on the GMC's specialist register. These monthly checks had been put in place following the previous inspection.

The pharmacy's RA for providing aesthetic products included making checks on the registration of prescribers when they registered with the pharmacy, and on a monthly basis. It also included the requirement to complete an ID check, although the RA did not specify what the ID checks entailed. Prescribers were required to confirm they had appropriate indemnity insurance when they opened an account with the pharmacy. The RA included a control that limited the quantities dispensed of any aesthetic product to not more than 5 packs. And the RA required team members to query with the prescriber any prescriptions which were for more than 5 packs. The RA did not explain the rationale for

why 5 packs was chosen as the maximum quantity. A sample of the patient medication record (PMR) data showed that no more than 5 packs were being issued. The RA mitigated some risks of face-to-face consultations not taking place but it relied on the prescriber signing a declaration on the prescription. The date of when this happened was not recorded and no further checks or audits were completed to independently verify the information provided by the prescriber. A sample of prescription data showed people's addresses were geographically close to the prescriber's address. The RA did not identify specific frequencies at which people were able to have their aesthetic medicines dispensed. The last inspection had identified that the SOP for dispensing non-surgical medicinal products did not include guidelines about acceptable frequencies, so this process was unchanged from the previous inspection. A sample of prescription data seen did not highlight any concerns regarding the frequency of supplies.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The small volume of prescriptions dispensed meant it was more difficult to identify trends in mistakes. The pharmacist recorded details of mistakes electronically and any near misses were discussed at the time with the team member who made the mistake. The pharmacy electronically recorded errors that were identified after a person had received their prescription, known as dispensing errors. These were processed in the same manner as the near misses. After the inspection, some errors were identified by the inspectors in the patient medication record (PMR) data which was queried with the SI. The SI confirmed these were a labelling error for a patient who was prescribed an aesthetics product, and an incorrect quantity recorded on the PMR. These errors had not been recorded at the time. The SI confirmed the errors would be recorded.

The pharmacy completed a monthly audit which involved the RP and SI. The audit reviewed the previous month's activities and identified any near misses, incidents, and whether checks had been completed that month. These checks included that shared care agreements were up to date, and that prescriber and clinic verification checks had been completed and if CD balance checks had been completed. The pharmacy's audits captured details about whether any interventions about excessive quantities had been identified. An audit from January 2024 confirmed the pharmacy had not identified any prescriptions with excessive quantities that required intervention. Another audit detailed an intervention and query checked with a clinic about prescribed quantities of hydroxycobalamin ampoules. Any interventions were also captured on a spreadsheet specific to the clinic involved.

The pharmacy had a procedure for dealing with complaints and concerns, which it received either via telephone call or email. And people could submit their complaints via the website. Team members aimed to resolve complaints informally and could escalate them to the SI if necessary. The SI explained they had received some complaints about the quality of medicine dispensed and this had been raised with the manufacturer to resolve.

The pharmacy had current professional indemnity insurance. Team members had knowledge about RP regulations and the tasks that could not be completed if the RP wasn’t present. The pharmacy displayed the correct RP notice in the pharmacy. Its RP record was captured electronically on the PMR system and was completed correctly, with annotations about absences correctly documented. The pharmacy recorded the receipt and supply of its controlled drugs electronically. And records showed they were mostly completed correctly, with the occasional address of the supplying wholesaler missing. Team members completed checks of the physical quantity of stock held against the register running balance at both the point of dispensing and weekly. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. And they were separated from routine stock in the CD cabinet, to reduce the risk of inadvertently mixing with routine stock. The destruction of the CD medicines was witnessed by a pharmacist. The pharmacy kept an electronic record of its private prescriptions. And the details of two randomly selected private prescriptions matched the details in the

private register. Original private prescriptions for controlled drugs were generally sent to the relevant authority for audit purposes, and a copy kept in the pharmacy. Approximately 15 private prescriptions from January 2024 had not been sent to the relevant authority and the SI confirmed this would be resolved.

Team members were aware of their responsibility to protect people's private information. And there was a privacy notice on the company's website informing people of how their private information was used. They had completed training about General Data Protection Regulation (GDPR). And they separated confidential waste for secure destruction by a third-party company. The pharmacy had a SOP about safeguarding vulnerable adults and children which included details of local authorities they could contact in the event of a concern. And the RP had completed safeguarding training in 2023. The SI explained if the concern was for a person who was not local to the pharmacy, they would contact their local authorities for advice or using the internet to find the relevant contact details for the person's nearest safeguarding authority.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members for the specialist services they provide. Team members complete training relevant to these services to keep their knowledge up to date. And they can raise concerns if needed.

Inspector's evidence

The pharmacy employed a resident pharmacist who was the RP. The pharmacy's SI was regularly available at the pharmacy. The pharmacy had a pharmacy technician, and two dispensers, one of whom was a trainee. Team members had either completed accredited training or were enrolled on accredited training. The RP acted as tutor for the trainee dispenser. The RP had completed additional training about cannabis-based products for medicinal use and was developing their knowledge in relation to ADHD.

Team members worked for both the pharmacy and the parent company's wholesalers and were not always present in the pharmacy due to small volume of workload. During the inspection, only the RP and the SI were present. Dispensers were employed by the parent company full-time and worked part-time in the pharmacy. Annual leave was planned in advance so that contingency arrangements could be made which involved team members increasing their hours in the dispensary. Annual leave for the pharmacist was usually covered by a locum pharmacist who was experienced in the specialist medicines dispensed by the pharmacy. On the rare occasion the locum was unavailable, the pharmacy closed when the resident pharmacist was absent. And this only occured for very short periods of a day or two. The locum had completed training about the specialist medicines and shadowed an experienced pharmacist before working in the pharmacy.

Team members received development reviews twice yearly with the SI where they could discuss progression and identify any training needs. The parent company had a whistleblowing policy for its team members. The pharmacy did not set targets for its team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean and suitable for the provision of its services. The pharmacy's website provides clear information about the pharmacy and its registration status.

Inspector's evidence

The pharmacy's premises were based in a larger office in the parent wholesaler's company. The pharmacy's website provided information for people and prescribers about the products supplied and how medical prescribers were to submit their prescriptions. The website provided details about the owners, its physical location and contact details. It also provided the name and registration detail of the SI.

The pharmacy's premises were spacious, light and the temperature was comfortable. There were various bench spaces for the completion of tasks. And benches were free from clutter. Team members kept the pharmacy clean according to a rota which was up to date. The pharmacy had a sink which provided hot and cold water. And separate toilet facilities provided hot and cold water and soap for handwashing.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services safely. It completes checks to ensure people receive their medicines correctly. And it packages medicines appropriately for delivery to ensure they are suitable for people to use. The pharmacy sources its medicines from recognised suppliers. And team members complete checks on medicines to ensure they remain fit for supply. They respond appropriately to alerts about the safety of medicines. And they mostly follow procedures and guidance. But not all the prescriptions they dispense state the directions for use. And so they cannot be sure these medicines are appropriate for people to use.

Inspector's evidence

The pharmacy was closed to the public, this means people did not visit the pharmacy to access services. The RP confirmed that on occasion people had arranged to collect their medication from the pharmacy. And they were met at the reception area associated with the parent company. The pharmacy team spoke to people on the telephone to counsel them about their medications. The pharmacy's website provided details about how medical professionals and patients used the prescription ordering and delivery service.

The pharmacy received paper copies of the prescriptions from the prescribers. The pharmacy had a template prescription that was used by prescribers of aesthetic products. The pharmacy dispensed a small number of prescriptions for botulinum toxins with non-specific directions which was contrary to guidance published by the Joint Council for Cosmetic Practitioners (JCCP). This means that the pharmacy cannot always assure itself they were being used appropriately and within their licenced indication. Prescriptions for botulinum toxins issued with non-specific directions were seen at the previous inspection and so the pharmacy had not changed their processes, although they were dispensing less botulinum toxins than at the last inspection. The supplies of the botulinum toxins were within the pharmacy's allowable limits as per their RA. The pharmacy sourced its supplies of aesthetic products from recognised suppliers. The PMR data showed that all other prescriptions, including unlicenced CDs had directions on to help people to use their medicine correctly.

Some prescriptions dispensed for CBPMs, from a sample of prescription data seen, were for quantities greater than a 30-day supply. The SI confirmed quantities were monitored and queried with the prescriber and details recorded in the pharmacy's intervention tracker for the clinic. The pharmacy sourced its CBPMs from a licensed manufacturer and importer and its own parent wholesaler.

Most medications were delivered to people. And the pharmacy packaged the medicines in plain packaging so that the contents could not be identified. The pharmacy spoke to people before their deliveries were due and used a tracked for postal service. The deliveries required a signature upon receipt which was then checked the next day on the postal service's website by the RP to ensure that packages had been delivered. On occasion, people requested their medicines be delivered to an address that was not their home address, for example a work address. The pharmacy verified the request by asking for a written request to come from the person's verified email address. Aesthetic products were not delivered to the patient but were delivered to the clinic that was administering the product.

Team members used baskets to keep people's prescriptions and medicines together to reduce the risk of mix up. And they signed labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of who was involved in the process. Team members checked the expiry date of medicines and records showed this was up to date. The pharmacy did not stock many medicines, so all stock was checked at one time. Team members highlighted any medicines going out of date in the next three months for use first. And they checked the expiry dates of the medicines during the dispensing and checking processes. A random selection of 10 medicines showed none past their expiry date. The pharmacy had a fridge for medicines that required cold storage. The fridge had a thermometer which continuously monitored and tracked the temperatures. Records showed that the fridge was operating between the required two and eight degrees Celsius. Any deviations of the temperature outside the required two and eight degrees Celsius prompted an automatic email alert to the SI to take action. The pharmacy received notifications about drug alerts and recalls via the Medicines and Healthcare Regulatory Agency and via their suppliers. The pharmacy actioned the drug alerts and kept a record of those actioned by the pharmacy. The pharmacy ensured out of date medicines were kept separately for uplift and destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely and it uses the equipment in a way which protects people's private information.

Inspector's evidence

The pharmacy had access to a range of electronic reference resources including specialist pharmacy service (SPS), the British National Formulary (BNF), British National Formulary for children (BNFc) and medicines complete. It had some literature provided from the manufacturers of the CBPMs to help the RP complete their clinical check. The pharmacy packaged medicines requiring cold storage with chilled packaging from specialist company. This had been validated by the pharmacy and parent wholesaler to confirm medicines in transit to people were maintained within the required 2-8 degrees Celsius.

The pharmacy's records were stored within cabinets in the pharmacy which was inaccessible to people. People's private information was stored on computers which were password protected and kept within the pharmacy to protect people's private information. The pharmacy had its own telephone for the RP to have conversations with people.

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.