General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicines2Home.Com, Suite 3 Railway House, Station Street, Meltham, Huddersfield, West Yorkshire, HD9 5NX

Pharmacy reference: 1109850

Type of pharmacy: Internet / distance selling

Date of inspection: 12/01/2023

Pharmacy context

The pharmacy is in a business centre in Meltham. It has a distance selling NHS contract. Pharmacy team members dispense NHS prescriptions and deliver them to people's homes. They provide medicines to some people in multi-compartment compliance packs. And they provide medicines and advice to people referred to the pharmacy via the NHS Community Pharmacist Consultation Service (CPCS).

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.4	Standard not met	Pharmacy team members do not employ adequate security arrangements in the pharmacy.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have an adequately robust processes for checking medicines' expiry dates. And it does not always store medicines in an organised manner. It does not keep all its medicines in the original packs or label medicines removed from original packs properly, which increases the risk of errors.
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 risks. It has the written procedures it needs relevant to its services. Pharmacy team members consider the risks of providing services to people. But they don't make records of these assessments to help with ongoing reflection and risk management. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss the mistakes they make so that they can learn from them. But they don't always capture key information or analyse these records, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks associated with its services. The superintendent pharmacist (SI) had reviewed the SOPs in 2022. Pharmacy team members had signed to confirm they had read and understood the procedures since the last review. The SI had set a date to review them again in 2024.

The pharmacy provided advice and treatment to people for various minor ailments via the NHS Community Pharmacist Consultation Service (CPCS). People were referred to the pharmacy for the service mainly by their GP surgery, or sometimes after contacting NHS111. The pharmacy had an SOP explaining how team members should deliver the service. And Pharmacy team members had completed the necessary mandatory training to deliver the service. The pharmacist explained how team members had considered the risks associated with the service. But they had not documented their risk assessment to be able to refer to it later. The pharmacist explained that one risk they identified was their lack of knowledge of treating minor ailments in children. So, they had completed further learning by shadowing local GPs to observe and discuss how they assessed and treated children for various conditions. The pharmacist explained they had good a good working relationship with local GPs. And they were able to easily contact them to discuss a diagnosis or to refer people to them for further assessment. The pharmacist recorded their consultations with people. But in some examples, the pharmacist had recorded little information about how they had made their diagnosis. This meant it might be difficult to easily make further assessments or deal with future queries.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made. There were documented procedures to help them do this effectively. They used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as propranolol and prednisolone, to help prevent the wrong medicines being selected. The records available contained little or no information about why mistakes had been made. Or the changes team members had made to prevent them happening again. The pharmacist looked at the data collected ad hoc to establish any patterns of errors. And they discussed the patterns found with the team. But they did not have a formal process for analysing errors. And they did not record their analyses. This meant they might miss opportunities to reflect, learn, and make improvements to the pharmacy's services. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. The pharmacist explained they had not made any dispensing errors, so there were no completed records to see. This meant the inspector was unable to assess the quality of

the pharmacy's response to dispensing errors at this inspection.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It advertised a complaint's procedure to people on its website. But the information was out of date and contained the details of the pharmacy's previous SI as the person to contact. The pharmacist gave his assurance that the details would be updated and made accurate as soon as possible. The pharmacy had up-to-date professional indemnity insurance in place. It maintained a responsible pharmacist (RP) record, which contained some gaps in the sign-out time of the RP, which compromised the accuracy of the record. The pharmacy kept controlled drug (CD) registers complete and generally in order. But several registers consistently did not have completed page headers. This increased the risk of entries being made in the wrong register. Pharmacy team members kept running balances in all registers. These were audited against the physical stock quantity approximately every two months. The inspector checked the running balances against the physical stock for three products. And these were all found to be correct. The pharmacy kept private prescription and emergency supply records, which were complete and up to date.

The pharmacy was not accessible to the public because of the nature of its distance selling NHS contract. So, it kept sensitive information and materials securely in the pharmacy. It collected confidential waste in dedicated bags. These bags were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information correctly. Team members explained how important it was to protect people's privacy and how they would protect confidentiality. The pharmacy had a documented procedure for dealing with concerns about children and vulnerable adults. And some printed guidance materials and local contact information for team members to refer to. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And they explained how they would refer any concerns to the pharmacist. Pharmacy team members had completed safeguarding training in 2022. And the RP had last completed training in 2021.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide, or they are completing appropriate training courses. And they keep their knowledge up to date. They effectively discuss and implement changes to improve their services and the way they work. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the pharmacy team members present were the pharmacist manager and a dispenser. The pharmacy also employed two part-time trainee dispensers and three part-time delivery drivers. All team members had completed appropriate training for their roles or were enrolled on appropriate accredited training courses. And they also completed ad hoc ongoing learning. Some recent examples of training included online training modules about safeguarding and dealing with dispensing errors and incidents. Team members also regularly discussed learning topics informally with the pharmacist. And the pharmacist provided information or signposted them to relevant materials and resources to help answer their questions. The pharmacy did not have a formal appraisal process. But team members had an informal discussion with the pharmacist at least once a year to discuss their progress. They explained they would raise any learning needs with the pharmacist informally. And they were confident the pharmacist would support them to find the information they needed.

Team members explained how they would raise professional concerns with the pharmacy manager or their superintendent pharmacist (SI). They felt comfortable raising concerns. And felt their new SI was very approachable and open to discussions. Team members also felt comfortable making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. Team members had made some changes to the pharmacy since its last inspection. They had changed the way they used the space in the pharmacy to help improve their workflow, especially for assembly of multi-compartment compliance packs. And they had reviewed and reorganised some key documents to make them relevant to the pharmacy’s current operation. The pharmacy did not have a formal whistleblowing policy. Pharmacy team members said they would raise any concerns anonymously with GPhC or the NHS.

Principle 3 - Premises **Standards not all met**

Summary findings

Pharmacy team members do not properly secure the pharmacy to prevent unauthorised access during working hours. The pharmacy is clean. And it provides a suitable space for the services it provides.

Inspector's evidence

The pharmacy was in a shared business unit. The pharmacy could be secured, but pharmacy team members did not always properly control access to the pharmacy to help prevent unauthorised access during working hours. The pharmacy had a large room used for dispensing and storage. The pharmacy was generally tidy. It had defined areas for dispensing and checking. The floors and passageways were free from clutter and obstruction. There was a defined workflow in operation. There was a clean, well-maintained sink used for medicines preparation. There was a toilet, a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was adequate for the services being provided.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always manage its medicines appropriately. Pharmacy team members do not follow the pharmacy's documented process for checking the expiry date on medicines. And they do not always keep medicines in the original packs or store all medicines appropriately. The pharmacy sources its medicines from reputable suppliers. It generally supplies medicines to people safely and it has some processes to manage the risks and provide advice for people taking high-risk medicines.

Inspector's evidence

People did not visit the pharmacy, but they communicated with the pharmacy by telephone, email and by using the pharmacy's online prescription ordering system. The system enabled people to tell the pharmacy which medicines they needed. And the pharmacy ordered prescriptions on their behalf. The pharmacy had a website, medicines2home.com, where it provided its contact details. People could purchase a range of over-the-counter medicines via the website, but this service was provided and administrated by a third-party company. Pharmacy team members could provide large print labels for people with visual impairment. They said they would communicate in writing with people with a hearing impairment.

The pharmacy had a documented procedure for checking stock for short-dated and expired medicines. The procedure had been updated and read by pharmacy team members since the last inspection. The procedure instructed team members to complete these checks once every three months. But team members explained they had not been able to keep up with the schedule because of ongoing workload pressures and staff shortages. They last completed a check of the pharmacy's medicines in August 2022. They recorded that the check had been completed. They highlighted medicines expiring within 12 months of the check by attaching a sticker to each pack. And by completing a monthly expiry sheet. After a search of the shelves, the inspector found four medicines that were out of date. All these medicines expired at various dates between October and December 2022 and had been highlighted as short-dated according to the procedure. The shelves where medicines were kept were generally untidy, which increased the risk of team members selecting the wrong medicine. Several boxes were found containing mixed batches of medicines. This meant the batch number and expiry date of the medicines did not match those printed on the box. All these findings increased the risks of someone being supplied with out-of-date medicines, or medicines that had been subject to a safety recall.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. The pharmacist did not record these conversations with people to help with future queries. And the pharmacy did not carry out any regular audits to help identify people at risk.

The pharmacy supplied medicines for people in multi-compartment compliance packs when requested.

It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines regularly. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR).

The pharmacy delivered medicines to people. It recorded the deliveries made. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The driver attempted to redeliver people's medicines over three consecutive days before alerting the pharmacist, who then investigated and contacted the person's GP. The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides. It generally manages and uses its equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view.

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.