General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Medwin Pharmacy, Unit A10, Meadowbank Industrial Estate, Harrison Street, ROTHERHAM, South Yorkshire, S61 1EE

**Pharmacy reference:** 1115386

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 30/03/2022

## Pharmacy context

This is a distance selling pharmacy which offers services to people through its website www.medwinpharmacy.com. The pharmacy specialises in supplying medicines in multi-compartment compliance packs to people residing in care homes. It also sells medicines online through an eBay shop. The pharmacy premises are not generally accessible to members of the public due to its distance selling model. This means the pharmacy supplies all medicines through a delivery service. This inspection took place during the COVID-19 pandemic.

## 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 acts to identify and manage risks associated with providing its services. It seeks feedback from people accessing its services. And it uses the feedback it receives to inform improvement. The pharmacy generally keeps the records it needs to by law up to date. And it protects people's private information appropriately. Pharmacy team members have the knowledge and ability to recognise and raise concerns to help safeguard vulnerable people. They act openly and honestly by discussing mistakes made during the dispensing process. And they act to reduce risk following these discussions.

### Inspector's evidence

The pharmacy had considered some risks of providing its services during a pandemic. These centred around adapting processes for delivering medicines to care homes. For example, the pharmacy had a process for contactless delivery with checks made to ensure medicines were received safely. The pharmacy had maintained the requirement for care homes to sign for controlled drugs (CDs). Team members had supplies of personal protective equipment available to them but they did not routinely wear face masks whilst working. The pharmacy was not accessed by members of the public as it provided all of its services at a distance.

The pharmacy had a set of standard operating procedures (SOPs) designed to support the safe running of the pharmacy. Current SOPs had been due for review in 2021. The superintendent pharmacist (SI) was in the process of reviewing all SOPs. Evidence of this review process was provided. Most team members with the exception of new starters had read and signed the SOPs. And team members demonstrated how they worked in accordance with SOPs. For example, bringing requests for Pharmacy (P) medicines via the eBay shop to the attention of the responsible pharmacist (RP) for review. The pharmacy management team demonstrated how it had risk assessed its services. For example, the pharmacy had a specific risk assessment to support it in managing the risks associated with selling medicine via eBay. This was a live document and was updated regularly.

The pharmacy had a near-miss error reporting tool. There was some inconsistencies in reporting throughout the pandemic. But a review of the record confirmed recent efforts to improve reporting. A team member explained that they would enter their own near misses following feedback from a pharmacist. There was scope to improve the quality of the entries made. For example, learning points prompted the need to double-check repeatedly. There was no formal review of the record documented. This meant it was more difficult for the team to establish if the learning points had supported the team in reducing risk. Team members did engage in conversations about their mistakes. These conversations included a focus on identifying the potential consequence of a mistake. And team members demonstrated actions taken to reduce risk. For example, 'look-alike' and 'sound-alike' (LASA) medicines were separated on dispensary shelves. The pharmacy had a procedure and relevant tools available for reporting dispensing incidents. A team member explained there had been no reported incidents within the last two years. The documented procedure involved reporting to the National Reporting and Learning System (NRLS) . A discussion relating to updating this information to reflect the change in national reporting took place, this involved the pharmacy reporting to the new NHS 'Learn from patient safety events' (LFPSE) service rather than to NRLS.

The pharmacy had a complaints procedure in place and it advertised how people could raise a concern or provide feedback through its website and practice leaflet. The pharmacy team discussed changes to the care home service following some feedback it had received. Changes included introducing 'early-morning' compliance packs for medicines required to be taken before breakfast. The pharmacy monitored feedback received through eBay and a team member demonstrated how the pharmacy took this feedback onboard to seek improvements when needed. For example, the importance of securely packaging medicines in glass containers. The team had access to procedures and contact details for local safeguarding teams. Some members of the team had completed training associated with recognising and raising concerns about vulnerable people. The pharmacist effectively talked through a hypothetical safeguarding scenario involving the repeated supply of a high-risk medicine.

The pharmacy had up-to-date professional indemnity insurance in place. The RP notice displayed did not belong to the RP on duty. This was swiftly replaced with a notice reflecting the correct details of the RP on duty once brought to their attention. There were some minor gaps in the RP record. And a discussion took place about each RP's individual responsibility to ensure this record was maintained. The pharmacy's CD register was generally kept in accordance with legal requirements but page headers were not always completed. The pharmacy kept running balances within the CD register and it completed full monthly balance checks of physical stock against the register. The pharmacy held its specials records in accordance with the Medicines and Healthcare products Regulatory Agency's requirements. The pharmacy had procedures related to how it managed people's private information. It was registered with the Information Commissioner's Office (ICO). The pharmacy kept records associated with the secure collection and destruction of its confidential waste. It held all personal identifiable information within the registered premises. And there was no public access into the dispensaries.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough people working to provide its services. It recognises the risks associated with having a high number of trainee team members. And it acts appropriately to manage and monitor this risk. Pharmacy team members engage in regular discussions focussed on patient safety and managing workload. They show how they work within their respective roles. And they understand how to raise a concern at work.

### Inspector's evidence

The RP on the day of inspection was the SI. On duty alongside the SI was a pre-registration pharmacy technician, a delivery driver, two qualified dispensers and eight trainee dispensers. Workload was well managed and up to date. Two other regular pharmacists also worked regular shifts at the pharmacy across its six-day working week. The pharmacy employed another qualified dispenser and had support from a further qualified dispenser during periods when staffing levels were low. The pharmacy had experienced a high-turnover of staff in recent months. This resulted in a high-proportion of team members in training roles. Most trainees, with the exception of those employed within the last six weeks, were enrolled on a GPhC accredited training course. The number of trainees did increase risk. And the pharmacy had recognised this and had put in systems to help reduce risk and support trainees. A qualified and experienced dispenser was always on duty. And new tasks for trainees were introduced gradually. For example, a qualified dispenser picked the medicines for assembly in a compliance pack. A trainee dispenser demonstrated her own checks of these medicines against the medication administration record (MAR) and prescription prior to assembly of the compliance pack. And she went on to explain that she would not assemble compliance packs containing more than five medicines due to the increased complexity of the task.

Pharmacy team members engaged in weekly team briefings. As well as covering workload management the meetings focussed discussions on patient safety and the delivery of services. Team members spoken to confirmed they were confident at providing feedback and sharing their ideas at work. And one team member demonstrated how a very recent discussion following feedback from a care home about the application of medicine patches to its residents had led to positive change. A new process involved team members highlighting the date on which a patch required changing on the MAR , and crossing through other days to help reduce the risk of error. Details of the change was clearly documented and displayed on the pharmacy’s dedicated information wall. The pharmacy also displayed some relevant training certificates issued to team members on this wall. Another team member was able to explain how they could raise and escalate a concern at work if needed. Team members engaged in conversations related to their performance and development. But the pharmacy did not provide scheduled protected training time to its trainees. Trainees confirmed they received regular support and time alongside breaks during quieter periods. The pharmacy owners had not set specific targets for its team members to meet. There was a focus on ensuring medicines were delivered in accordance with strict timescales.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are appropriately secure and maintained. They offer a suitable environment for delivering pharmacy services.

### Inspector's evidence

The pharmacy website included the name, address, and contact information for the pharmacy. The pharmacy did not use the GPhC voluntary internet pharmacy logo. But it did provide details of the registration status of the SI and of the pharmacy through live links to the GPhC registers. The pharmacy premises were appropriately secure and maintained. The pharmacy was relatively clean and organised. Team members shared regular cleaning tasks which included daily cleaning of workspaces. The dispensary floor required some attention as paper debris built-up between scheduled hoovering tasks. The pharmacy had adequate heating facilities. It was generally well-lit with some attention required in one area of the dispensary as a bulb required replacing.

The premises consisted of a foyer with access to staff facilities and two dispensaries. One dispensary was used solely to manage the eBay shop sales. It consisted of separate rooms used to complete administration tasks and dispensing tasks. The main dispensary was a good size and was fitted with ample workstations. It had a mezzanine level which the team used for storing medicine waste containers at the far end. The mezzanine level also provided a staff break area for team members. Pharmacy team members used the dispensary sink for making drinks and reconstituting liquid medicines. The pharmacy had separate hand washing facilities onsite. These were equipped with antibacterial hand wash and paper towels.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy obtains its medicines from reputable sources. And it has systems to ensure it stores its medicines safely and securely. Its team members complete a range of checks and audit processes which assist the pharmacy in providing its services safely. And its services are generally accessible to people. But it does not always act to ensure all information on its website or eBay listings are accurate. This may reduce the confidence people have in accessing its services.

### Inspector's evidence

People accessed the pharmacy's services through either the website, its eBay shop, by email or by telephone. Some information on the pharmacy's website was not up to date. For example, the website referred to some face-to-face travel health services. A team member confirmed the pharmacy no longer provided this service and its consultation space had been refitted to provide the eBay shop service. The website included an A-Z health information guide. It also offered General Sales List (GSL) and P medicines for sale. This service was provided by a third-party pharmacy registered with the GPhC. The pharmacy did not advertise details of this third-party provider prominently on its website. But information was available upon check-out of baskets when people purchased medicines. And further information about the arrangement was set out within the 'terms and conditions' section of the website.

The pharmacy had specific procedures in place for the sale of medicines through its eBay shop. Team members involved in tasks associated with the supply of these medicines were able to discuss and demonstrate how they managed risk. Medicines were picked against printed copies of orders. And people could choose their delivery option, including tracked delivery if required. The pharmacy limited the supply of some medicines to one per transaction. And it clearly advertised this policy to people through its eBay listings. The pharmacy had daily check processes to identify repeat orders for higher risk medicines liable to abuse and misuse. It displayed details of these medicines on a wallchart to help prompt additional checks. This process included checking for multiple orders of single items made within a short time scale. There was a full audit trail of both cancelled orders and banned user accounts. A team member explained that accounts were banned following appropriate warnings being sent to people attempting to order above the maximum quantity permitted. A fortnightly audit was used to monitor the effectiveness of the daily audit process. And on occasion identified multiple user IDs within the same household. In these circumstances action was taken to cancel any unsent orders and block accounts found to not be adhering to the terms and conditions of sale.

The pharmacy followed eBay user guidance when selling its medicines through the platform. It used eBay templates available on the platform to list some medicines. But there were some minor spelling mistakes within some listings. For example, Nurofen was spelt Nurafen within the listing. The pharmacy was aware of the issue and had received some feedback about it. A discussion took place about the need for the listings to reflect the accuracy and professionalism that members of the public associated with a registered pharmacy. The RP on duty was responsible for authorising the supply of all P medicines through the eBay shop. And the pharmacy had clear processes to support the RP in doing this. It required people requesting most P meds to complete an additional questionnaire in order for the RP to assure themselves that the sale was appropriate. But it was identified during the inspection

that the pharmacy had not put in a questionnaire for the supply of clotrimazole 2% cream. This made it more difficult for the RP to establish if the product was suitable for the person requesting it. The pharmacy did have contact information for people requesting medicines in this way, and the RP could discuss the request directly with the person if needed. But a discussion took place about the risks associated with not recording these decisions due to the inconsistency between the approach of supplying this P medicine when compared to others. And the discussion highlighted the need for one consistent approach. The pharmacy acted quickly on this feedback by introducing a questionnaire shortly after the inspection.

Pharmacy team members could identify higher risk medicines. And the team demonstrated how it supplied warfarin monitoring records and body maps to care homes. But it did not routinely ask for monitoring records prior to supplying these medicines. The pharmacy did not supply higher risk medicines in compliance packs. The pharmacy team was aware of the requirements of the valproate pregnancy prevention programme. And the pharmacy had the necessary patient cards and guides to issue if it received a prescription for valproate for a person within the high-risk group.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. Pharmacists had access to original packaging used to fill compliance packs, along with MARs and prescription forms to help inform their clinical and accuracy checks. It kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy team had an established process for ordering and checking prescriptions prior to the assembly process beginning. This process was completed by qualified dispensers using copies of re-ordering MARs alongside patient medication records (PMRs) and prescription forms. Care homes were notified of queries and missing items via telephone calls. Changes to medication regimens were generally recorded on PMRs. Allergy status and special requirements were identified on MARs. Patient information leaflets were provided for new medicines, changes to the brand of medicine dispensed or upon request. The pharmacy also supplied MAR sheets with the supply of interim medicines to homes. These medicines were sent in original packaging with the patient information leaflet included. The pharmacy used its information wall to display important documents. For example, local NHS good practice guidance to care homes relating to expiry dates of medicines. This helped the team to provide accurate advice when speaking to care home staff. The pharmacy used a range of licensed wholesalers and a licensed specials manufacturer to obtain medicines.

The pharmacy stored most medicines in their original packaging in an orderly manner in the dispensary on designated shelving. Some medicines were held in clear tubs clearly labelled with details of the medicine inside, including the batch number and expiry date. These medicines were used to fill compliance packs. But the pharmacy team did not record the date of assembly on the tub. A discussion took place about the importance of retaining this information to help ensure the medicine remained safe and fit to supply once removed from its original packaging. And the team acted on the feedback immediately by introducing a further label to the tub to capture this information. The pharmacy fridge was clean and it was an appropriate size for the stock and assembled cold chain medicines held. The team kept an electronic record of fridge temperatures but this had frequent gaps requiring attention. Temperature records either side of the gaps confirmed the fridge was operating between two and eight degrees Celsius as required. The pharmacy kept its CDs in secure cabinets and medicines storage inside was orderly.

The team kept date checking records and checks were regularly carried out. A random check of stock across the dispensary found no out-of-date medicines. The pharmacy had medicine waste bins and CD denaturing kits available to support its team members in managing pharmaceutical waste. The

pharmacy received details of medicine alerts and drug recalls through email. It kept an electronic audit trails of the alerts it checked. And displayed relevant alerts on information wall.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has a suitable range of equipment to support the delivery of its services. It uses regular monitoring processes to ensure its equipment remains safe to use. And its team members use the equipment in a way which protects people's privacy.

### Inspector's evidence

Pharmacy team members had access to up-to-date written and electronic reference resources. For example, the British National Formulary (BNF). And they could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. It stored counting apparatus for tablets and capsules, and a British Standard measuring cylinder within the dispensary. It had a range of desktop and laptop computers available to support the supply of medicines. Computers were password protected and team members with access to PMRs used NHS smartcards. Equipment associated with the supply of medicines in compliance packs was single use. And the pharmacy had invested in an electric de-blistering machine to support it in supplying medicines efficiently. The pharmacy used external companies to conduct safety testing and calibration of its equipment. For example, portable appliances had been checked for safety and the pharmacy fridge was calibrated in 2021. These checks helped to ensure equipment remained in good 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. |