General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medico2u, 11 Main Drive, East Lane, Wembley, HA9 7NA

Pharmacy reference: 9010917

Type of pharmacy: Internet / distance selling

Date of inspection: 14/10/2021

Pharmacy context

The pharmacy is in a business park in north west London. It is not open for people to visit in person as it provides its services at a distance. The pharmacy dispenses NHS and private prescriptions and provides health advice. It dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Its services include seasonal flu vaccinations and prescription delivery. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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 has satisfactory written procedures for its team to follow when providing its services and to help protect the wellbeing of vulnerable people. The pharmacy mostly keeps satisfactory records of the things it needs to by law. So, it can show the pharmacy is generally providing safe services. The pharmacy manages and protects confidential information. It has introduced new ways of working to help protect people against COVID-19 infection. The pharmacy now has sufficient professional indemnity insurance for the services it provides.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't routinely record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The RP explained that medicines involved in incidents, or were similar in some way, such as the names of both medicines or the appearance of the containers, were generally separated from each other in the dispensary. So, the pharmacy team members had placed amitriptyline and amlodipine packs on different shelves and separated sumatriptan and sertraline packs to help avoid mistakes when they were picking medicines.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not delivered to people until they were checked by the responsible pharmacist (RP). The pharmacy had standard operating procedures (SOPs) which included procedures for responsible pharmacist (RP), complaints and the services it provided. These had been reviewed during 2020. The pharmacy team members would follow the NHS flu vaccination service SOP when the service commenced. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who interacted with it. The supplier's delivery procedure had been modified so the delivery tote boxes were set down at the entrance and the delivery person retreated to two metres away while the pharmacy team signed for the delivery. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They were vaccinated against COVID-19 and were self-testing for COVID-19 twice weekly. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands regularly and used hand sanitising gel when they needed to.

The pharmacy displayed a notice that told people who the RP was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they should refer to the RP for help. And their roles and responsibilities were described within the SOPs. A team member explained that they would not dispatch medicines for delivery to people if a pharmacist wasn't present. The pharmacist asked the care homes for their views and suggestions on how the pharmacy could do things better. And received good feedback. People posted online feedback via Google reviews.

The pharmacy did not have adequate insurance arrangements in place, including professional indemnity, for the services it provided. But following the visit, the pharmacist contacted his insurers to arrange increased cover with immediate effect. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register which was kept up to date. And the stock levels recorded in the CD register were audited regularly. So, the pharmacy team could spot mistakes quickly. A random check of the actual stock of two CDs matched the recorded value in the CD register. The pharmacy recorded the private prescriptions it dispensed electronically. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. There was a small number of private prescriptions issued by pharmacist independent prescribers associated with the pharmacy. The pharmacy had supplied the medicines but some of the records were incomplete. Moving forward, the SI gave an assurance that notes on the consultation would be recorded on the patient medication record (PMR) along with the reason for the prescribing decision. The inspector signposted the SI to GPhC Guidance for Pharmacist Prescribers (Nov 2019). The risk of supplying medicines against a faxed prescription before receiving the original document was discussed. The flu vaccinations were due to be administered through the NHS patient group direction and SOP when the service commenced. The pharmacist was preparing to provide the NHS flu vaccinations to some service users and had arranged training and equipment needed to deliver the service.

The pharmacy's website displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Staff members had completed General Data Protection Regulation (GDPR) training and signed confidentiality clauses. And they were using their own NHS cards. The pharmacist registered with the information commissioner's office following the visit. The pharmacy disposed of people's personal information securely. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together and manage the pharmacy’s workload. They are well supported in keeping their knowledge up to date and are comfortable with providing feedback to improve the pharmacy services and raise concerns.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (also the RP), a part-time pharmacist who was a pharmacist independent prescriber (PIP) and a full-time pharmacy assistant. They worked well together. The pharmacy was associated with another PIP. The superintendent pharmacist had reviewed both PIPs portfolios. The pharmacy assistant had completed accredited training relevant to the role. He also delivered medicines to people. The inspector signposted the team to GPhC guidance for training support staff (Oct 2020).

The pharmacist allocated protected learning time for the pharmacy team to read training topics which were available online such as the SOPs, information governance, safeguarding and cardiopulmonary resuscitation (CPR). The pharmacist had completed training and signed up to the discharge medicines service (DMS). The pharmacist was signed up attend training and the other regular pharmacist was trained to deliver the flu vaccination service. The pharmacy received COVID updates via the NHS and the local pharmaceutical committee (LPC). The team members were comfortable with making suggestions on how to improve the pharmacy and its services at regular team meetings and they could raise a concern if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, secure and suitable for the services it provides. It keeps its workbenches clear and tidy enough to work safely. The pharmacy has introduced ways of helping to protect the pharmacy team members from COVID-19 infection. And it prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The pharmacy was on the first floor of an office building in a business park. The registered pharmacy premises were bright, clean, tidy and secure. And steps were taken to make sure the pharmacy and its team didn’t get too hot. There was sufficient lighting and ventilation. The pharmacy had a portable air conditioning unit. And it had a portable sink if needed. The pharmacy team had access to shared lavatory and kitchen facilities which were clean. The pharmacy didn’t have a consultation room as it was closed to the public. But people could contact the pharmacy by phone or email if necessary. The pharmacy had risk-assessed the impact of COVID-19 upon its premises and the people who interacted with it. The supplier’s delivery procedure had been modified to ensure the delivery person maintained a social distance while setting down the order. Members of the pharmacy team wore fluid resistant face masks and they washed their hands regularly and applied hand sanitiser when they needed to. The pharmacy’s website had displayed some information which was not up to date so it could be misleading to members of the public visiting the website. The RP confirmed that the pharmacy did not sell medicines or supply medicines via prescription online.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and it gets its medicines from reputable suppliers. It stores its medicines securely at the right temperature and its team members know what to do in response to an alert. The pharmacy provides suitable written information with its compliance packs to help people identify each of the medicines inside and to use their medicines safely. People with a range of needs can access the pharmacy's services. The RP gives advice to people about where they can get other support.

Inspector's evidence

The pharmacy team could be contacted by phone or email. The pharmacy's website displayed contact details for the pharmacy. The pharmacy team members could speak Arabic and Ghanaian and had access to Language Line. And they could provide labels with large print for people with impaired vision. The pharmacy signposted people to another provider if a service wasn't available at the pharmacy. People could contact the pharmacist independent prescribers (PIP) who would conduct a telephone or video consultation. Prior to issuing a prescription, the PIP could check the person's summary care and patient medication records during the consultation with the person's consent. The consultation notes were not seen on the patient record for a selected prescription. The inspector signposted the pharmacist to GPhC guidance for registered pharmacies providing pharmacy services at a distance including on the internet (April 2019) and guidance for prescribers (Nov 2019).

The pharmacist advised people on how best to take their medication via telephone or when delivering medicines to people. He was aware of the valproate pregnancy prevention programme. And he knew that people in the at-risk group who were prescribed a valproate needed to be advised of the risks, especially if they became pregnant . The pharmacy had the valproate educational materials it needed. The pharmacy delivered medicines to people as they were unable to attend its premises in person. And it kept an audit trail for each delivery it made to show that the right medicine was delivered to the right person. The pharmacy team called the person and checked they would be at home when they were delivering a CD and asked the person to check the CD before leaving it. The pharmacy also delivered medicines to people via a tracked service provided by a courier.

The pharmacy used a disposable and tamper-evident system for a small number of people who received their medicines in compliance packs. The pharmacy team managed prescription ordering on behalf of these people and checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs and the patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. The pharmacy supplied medicines in their original packs to the care home patients. The care home staff ordered their residents' prescriptions two weeks in advance of when the medicines were needed to allow time for the pharmacy to check the prescriptions with the home and deliver the medicines. Members of the pharmacy team initialled the dispensing labels to show which of them prepared a prescription. And there was a procedure for dealing with medicines that were owed to people.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It mostly kept its medicines and medical devices within their original manufacturer's packaging. The dispensary was clean and tidy. The pharmacy team checked the expiry dates of medicines. And it generally recorded when it had done a date-check. No expired medicines were found on the shelves. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept patient returned and date-expired waste medicines separate from stock in pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has appropriate equipment and facilities it needs for the services it offers. The pharmacy uses its equipment in a way that keeps people's private information safe.

Inspector's evidence

The pharmacy used electronic reference sources such as the electronic medicines compendium (emc). The pharmacist demonstrated the portable sink and access to potable water if required. And the stamped glass measures which were in use. The pharmacy team members stored medicines requiring refrigeration in the medical fridge. They showed how to monitor the minimum and maximum temperatures which were between two and eight Celsius. The pharmacy computer was password protected and backed up regularly. The information on the screen was not visible to anyone not authorised to see it. The pharmacy had sharps bins for flu vaccine sharps disposal and a cool box to transport flu vaccines. It stocked adrenaline injection devices to treat anaphylaxis when they provided the flu vaccination service during the forthcoming service.

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.