

Registered pharmacy inspection report

Pharmacy Name: MHS Pharmacy, Room 101-103, Kingfisher Business Centre, Burnley Road, Rawtenstall, Rossendale, Lancashire, BB4 8EQ

Pharmacy reference: 9010944

Type of pharmacy: Internet / distance selling

Date of inspection: 18/11/2021

Pharmacy context

This is a distance selling community pharmacy in a business centre in the village of Rawtenstall, Lancashire. It dispenses NHS and private prescriptions and sells some healthcare related products through its website. People do not access the pharmacy premises for services, so the pharmacy delivers medicines to people to their homes. It supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The inspection was completed during the COVID-19 pandemic.

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 team follows written procedures to help team members manage the risks associated with the services the pharmacy provides to people. Team members discuss why near miss errors happen during the dispensing process and put into place ways they can reduce the risk of similar errors happening again. The pharmacy suitably protects people's private information, and the team members are well equipped to help safeguard vulnerable adults and children. The pharmacy keeps the records it needs to by law, and these are mostly accessible.

Inspector's evidence

The pharmacy had introduced several ways to keep the pharmacy team and people who used the pharmacy safe from infection during the COVID-19 pandemic. Team members had discussed their own personal risk of COVID-19 with the pharmacy's owners, and they were socially distancing while they worked. There was hand sanitiser in the dispensary. People weren't asked to sign for the medicines deliveries they received from the pharmacy. This helped prevent spreading infection, for example through the sharing of pens between people and the delivery driver. The team regularly cleaned surfaces such as work benches and door handles. But the team members weren't wearing face coverings while they worked. The inspector reminded the team of the importance of wearing a face covering within a healthcare setting.

The pharmacy had a set of written standard operating procedures (SOPs) which were well organised with an index to help find a specific SOP. There were SOPs on various processes such as dispensing and the management of controlled drugs (CDs). During the inspection, the team was seen to be following the SOPs and one of the pharmacy's owners was completing an ad-hoc review of some of them. The pharmacy formally reviewed the SOPs each year to make sure the pharmacy's current ways of working were up to date. The last review was completed in February 2021. Each team member had read and signed the SOPs relevant to their role. Team members knew their roles and responsibilities, and they were aware of the tasks they could and couldn't carry out in the absence of a responsible pharmacist (RP).

The pharmacy had a process in place to record and report near miss errors made during dispensing. For example, if the team members had dispensed the wrong quantity or the wrong strength of the medicine. If the responsible pharmacist (RP) spotted a near miss error, they asked the team member to rectify the mistake as soon as possible. Team members were asked why the near miss error might have happened and to think about how they could stop it happening again. Team members recorded details of near miss errors into a near miss log. They recorded details such as the time and date of the error and any contributing factors. A dispenser explained he had noticed he had sometimes dispensed the wrong form of medicines. For example, dispensing capsules when the prescription asked for tablets. The dispenser explained the team had separated co-codamol tablets and capsules on the dispensary shelves, and this measure had helped reduce the number of errors. The pharmacy's superintendent pharmacist (SI) was immediately told about any dispensing errors that had reached people. The SI recorded any details of these errors on an online reporting system. The pharmacy advertised its complaints procedure on its website. People could either email or telephone the pharmacy to explain their concerns.

The pharmacy displayed an expired indemnity insurance certificate. Following the inspection, the pharmacy sent the inspector evidence of up-to-date indemnity insurance which expired in December 2021. An RP notice was clearly displayed in the dispensary. It was displaying the name and registration number of the RP on duty. The pharmacy kept a RP record that met legal requirements. The pharmacy kept registers for controlled drugs (CDs), and they met legal requirements. Every week, the team checked the balances in the registers against the pharmacy's stock to make sure they matched. During the inspection, a randomly selected CD's balance was checked. The balance was correct. The pharmacy kept records of CDs that were destroyed after people had returned them. The pharmacy occasionally dispensed private prescriptions and kept an electronic record of supplies. But the team couldn't access the records to show the inspector. The SI gave assurances that he would contact the computer system administrator to find out how to access the records. The pharmacy kept accurate records of supplies of specials.

The pharmacy had procedures in place to protect people's personal information. There was an information governance folder which contained various policies such as data protection and confidentiality agreements that had been signed by each team member. Team members placed any confidential waste into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed using a shredder. The RP and the SI had completed training on safeguarding vulnerable adults and children. And there was a written procedure for team members to follow if they had a safeguarding concern to report. Team members described some hypothetical situations in which they would raise concerns with the RP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members have the skills and knowledge to safely provide the pharmacy's services. They manage their workload well and support each other as they work. The pharmacy suitably supports its team members to continue to improve their learning. They collectively talk about mistakes made during the dispensing process to help them learn from each other and improve patient safety. The pharmacy encourages its team members to give feedback to help improve the way they work.

Inspector's evidence

The RP during the inspection was one of the pharmacy's owners. The RP was supported by the SI and four NVQ2 qualified pharmacy dispensers. The pharmacy also employed a full-time delivery driver. The RP and the SI worked alongside each other during each working day. During the inspection, team members were seen to be supporting each other in completing various tasks and managing their workload well. Team members explained they were able to dispense without feeling under pressure. This was mainly because the pharmacy premises were closed to the public.

The pharmacy supported its team members to complete training to help them continue to improve their knowledge and skills. Team members were given protected time during their working hours to complete training. They explained they were encouraged to ask the RP or SI questions about their training if they needed help. The team had recently completed training on dental health and suicide awareness.

The SI planned monthly meetings with team members to discuss topics such as the dispensing workload and near miss errors. Team members were asked if they wanted to suggest topics for the meeting agenda. Details of the meetings were documented so people who couldn't attend could read about the discussions when they next worked. The SI analysed the near miss log to see if there were any trends or patterns. Team members openly discussed their mistakes with each other. They explained this helped create a culture of openness and honesty and so they could learn from each other's mistakes. This helped improve the way they worked. The team members felt the pharmacy listened to their concerns. They had discussed with the RP and the SI how they felt overworked during the height of the COVID-19 pandemic. Team members were given additional support through the employment of relief dispensers and volunteers, and they were encouraged to take regular breaks from their work. There was a whistleblowing policy to help the team anonymously raise concerns.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean and secure and are suitable for the volume of services the pharmacy provides to people. The team works well to keep tidy the areas where it dispenses medicines.

Inspector's evidence

The pharmacy premises were well maintained and of a suitable size for the volume of services the pharmacy offered. The premises were kept clean and tidy. The main dispensary area was large and open plan. There were several work benches for team members to use to manage the dispensing process. The benches were kept tidy throughout the inspection. Medicines were tidily stored on shelves. There was another room used to store stock. The team had toilet facilities with hot water for handwashing. Lighting was bright throughout the premises.

People accessed some services and information through the pharmacy's website. It had the name, physical address and GPhC registration number of the pharmacy displayed on the website and the registration status of the pharmacy could be found by following the link from the premises number logo. The website displayed the name and registration number of the superintendent pharmacist on the home page.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a range of services that suitably supports people's health needs. The pharmacy appropriately manages and delivers its services. It obtains its medicines from reputable sources. And it stores and manages them as it should.

Inspector's evidence

The pharmacy advertised its services through its website www.mhspharmacy.com. And people could get in touch with the pharmacy through the 'contact us' page on its website, or via a telephone. The pharmacy had separate telephone numbers for general enquires and prescription enquiries. The pharmacy website outlined the pharmacy's opening hours. The website had a section displaying general information on many medicines and health care conditions. The pharmacy advertised some general sales list medicines through its website. The website was managed by an external contractor and the medicines were supplied from another pharmacy.

The pharmacy provided large-print labels on request to help people who had problems with their sight. Four team members were fluent in speaking Bengali and so could help Bengali speakers over the telephone with their healthcare needs. The pharmacy's website incorrectly displayed flu vaccinations as a service the pharmacy offered, and the pharmacy's postcode was also incorrectly displayed. The SI gave assurances that these errors would be rectified after the inspection.

Once medicines had been dispensed, checked and placed into bags, the team stored them on a bench in the dispensary. Team members used various stickers and put notes on the bags to use as an alert before the driver took them for delivery. For example, to highlight if a fridge line or a CD that needed delivering at the same time. Team members signed the dispensing labels to keep an audit of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. They used separate benches to carry out the dispensing process and final checks of prescriptions. The pharmacy provided owing slips to people on occasions when it could not deliver the full quantity prescribed. The delivery driver gave one slip to the person and one was kept with the original prescription in the pharmacy for reference when dispensing and checking the remaining quantity. Once the remaining quantity had been dispensed it was delivered to the person.

The pharmacy offered a repeat prescription ordering service. The dispenser telephoned people to either request their repeat prescription orders on their behalf, or remind them to place an order themselves. People were contacted around a week before their medicines were due to run out. The pharmacy kept a record of which medicines people had ordered. The team checked the records against the prescriptions to make sure they were accurate. The team was aware of the need to contact people via telephone to give people more information about their medicines if they were prescribed medicines that were high risk or required ongoing monitoring. The pharmacy had previously asked people who were dispensed warfarin for their INR records and these were recorded on the pharmacy's electronic patient record. But the pharmacy hadn't completed the process for several months. Team members showed their understanding of the pregnancy prevention programme for people who were prescribed valproate. They asked people questions to make sure they knew to use appropriate contraception. They didn't place dispensing labels over written warnings on packs and they attached a warning sticker on

the container if valproate was supplied outside of its original packaging.

Some of the prescriptions the pharmacy received were for people who benefitted from having their medicines dispensed in a multi-compartment compliance pack. People received their packs either weekly or monthly depending on their personal needs. When the pharmacy received the prescriptions, the team checked them against master sheets to make sure they were correct. The master sheets detailed which medicines went in the packs and at what time of the day they were to be taken. For example, in the morning or at bedtime. The team supplied the packs annotated with visual descriptions of the medicines. This was to help people identify their medicines. The team supplied patient information leaflets with the packs.

The pharmacy obtained medication from several reputable sources. Every three months, team members checked expiry dates of the pharmacy's medicines. They highlighted short-dated medicines on the shelves. They kept a record of which medicines were short-dated and when they were due to expire. The inspector didn't find any out-of-date medicines after a check of around 20 randomly selected medicines. The pharmacy received notifications of drug alerts and recalls. It actioned the alerts but didn't keep a record of the action taken. So, an audit trail wasn't in place. The pharmacy had a medical-grade fridge which it used to store medicines that needed cold storage. The team tidily stored the medicines in the fridge. Each day, the team recorded the fridge temperature records to make sure it was correctly operating. A sample seen were within the correct range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. And it appropriately uses its equipment to protect people's private information.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a CE quality marked measuring cylinder for liquids. The computers were password protected to prevent any unauthorised access. Team members had access to personal protective equipment including face masks and gloves.

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.