General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: MyMeds Pharmacy, 138 Salmon Lane, London, E14 7PQ

Pharmacy reference: 9011269

Type of pharmacy: Internet / distance selling

Date of inspection: 04/12/2024

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area near London city centre. People are not able to physically access the premises and the pharmacy provides its services at a distance. The pharmacy provides NHS dispensing services. It supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. The pharmacy uses third-party providers for its New Medicine Service and its online sales of over-the-counter medicines. This was the pharmacy's first inspection since it opened.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

Team members had read the pharmacy's up-to-date standard operating procedures (SOPs). And they had signed to show that they had understood them and agreed to follow them. Team members explained that the pharmacy would remain closed it the pharmacist had not turned up in the morning. And they knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. They explained that they would not hand medicines to the delivery driver if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

Items in similar packaging or with similar names were separated on shelves where possible to help minimise the chance of the wrong medicine being selected. Team members explained that near misses (dispensing mistakes that were identified before the medicine had reached a person) were highlighted with them at the time of the incident. And once a mistake was highlighted, they were responsible for rectifying it. Near misses were not always recorded so the pharmacy may be missing opportunities to learn from them and make improvements. The superintendent pharmacist (SI) said that he would ensure that near misses were recorded more frequently in future, and the record reviewed for patterns. Team members were not aware of any dispensing errors (dispensing mistakes that had happened, and the medicine had been handed to a person) since the pharmacy had opened. The SI said that pharmacy would record any dispensing incidents and undertake a root cause analysis. The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. The SI said that there had not been any recent complaints.

The pharmacy had current professional indemnity insurance. The private prescription and emergency supply records were completed correctly. The correct RP notice was clearly displayed, and the RP record was largely completed correctly. But there were a few occasions recently where the pharmacist had not made an entry on the day they had been RP and a few missing entries where the record had not been completed when the pharmacist had completed their shift. Controlled drug (CD) registers examined were filled in correctly and the recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

People could not see into the dispensary from outside the pharmacy. Confidential waste was shredded, computers were password protected and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about this. They described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. The SI

said that there had not been any safeguarding concerns at the pharmacy. The SI confirmed that the delivery driver would contact the pharmacy as soon as possible if they had any concerns about a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. The team members can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There were two pharmacists (one was the SI), two trained dispensers and one trainee dispenser working on the day of the inspection. The trainee dispenser had been enrolled on an accredited dispenser course. Holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. Team members were seen working well together during the inspection and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The pharmacy was seen to be up to date with its dispensing.

Team members appeared confident when speaking with people on the phone and they referred queries to the pharmacists when needed. The SI said that team members were not provided with ongoing training on a regular basis, but they did receive some. He said that he read pharmacy-related magazines and passed on relevant information to other team members. The pharmacists felt able to make professional decisions and they were aware of the continuing professional development requirement for professional revalidation. The SI had recently completed training for the NHS Pharmacy First service.

Team members explained that they had monthly team meetings to discuss any issues. And team members underwent an induction when they started working at the pharmacy. They had ongoing informal performance reviews and they felt comfortable about discussing any issues with the pharmacist. The pharmacy did not have any targets. The SI said that the pharmacy provided the services for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured against unauthorised access. And it was bright, clean, and tidy throughout. Air conditioning was available, and the room temperature was suitable for storing medicines. There was a kitchen area with a sink in the corner of the dispensary with hot and cold running water. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

The pharmacy's website displayed the pharmacy's name, address, GPhC registration number and details of the SI. And information was available in the privacy policy about how people's personal information was handled. The pharmacy used a third-party to manage its website and another pharmacy supplied the medicines.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely. The pharmacy gets its medicines from licensed wholesalers, and it largely stores them properly. It responds appropriately to drug alerts and product recalls.

Inspector's evidence

Services and opening times were clearly advertised, and a variety of health information was available on the pharmacy's website. Some team members could speak Bengali and they said that this helped support certain members of the local community access pharmacy services. And the pharmacy's contact details were available on the pharmacy's website. The pharmacy used a third-party provider for its online sales of medicines and the New Medicine Service (NMS). The SI explained that the pharmacy asked for people's consent before passing their details to the third-party provider for the NMS.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to help minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks.

The SI explained that the pharmacy routinely contacted people if there was a note on their prescription from the prescriber. But it didn't ask people about any relevant blood test results when taking higher-risk medicines. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not keep a record of any action taken. The SI said that he would ensure the pharmacy kept a record in future so that it could show that the appropriate action had been taken in the event of a concern or query. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. The pharmacy had not received any patient returned CDs since it opened. However, it had a book available to record these and the SI said that this would be use if CDs were returned to the pharmacy. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Short-dated items were not routinely highlighted which could

make it harder for the pharmacy to identify these. There were several boxes which contained mixed batches found with dispensing stock during a random spot check. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The SI said that he would ensure that medicines were kept in their original packaging in future.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. There were only a few part dispensed prescriptions at the pharmacy. The SI explained that this was due to how the pharmacy managed its workload and prescriptions were received around one week before people needed their medicines.

The pharmacy supplied medicines in muti-compartment compliance packs to some people. The SI explained that a suitability assessment was completed by the person's GP to identify which medicines were needed to be dispensed into the packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The SI explained that people were contacted to discuss which type of pack would suit their needs and what time of day they would be taking their medicines. The SI said that people contacted the pharmacy if they any 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines. Team members wore gloves when handling medicines that were placed in these packs.

Deliveries were made by delivery drivers. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines. Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only which helped avoid cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available online. And the shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.