

Registered pharmacy inspection report

Pharmacy Name: Medicines2Patient, 127 Bradford Road, Shipley,
West Yorkshire, BD18 3TB

Pharmacy reference: 9011487

Type of pharmacy: Internet / distance selling

Date of inspection: 01/11/2024

Pharmacy context

This is a distance selling pharmacy located in a residential area of Shipley, West Yorkshire. Its website is www.medicines2patient.co.uk. Its main services are dispensing NHS prescriptions and private prescriptions for a third-party online prescribing service company. People do not visit the pharmacy premises to access services, instead the pharmacy provides a home delivery service. It dispenses some medicines in multi-compartment compliance packs to people living in their own homes and in several local care homes.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy does not appropriately assess all the risks associated with supplying medicines against private prescriptions issued via a third-party online private prescribing service company. And it does not have sufficient written procedures, risk assessments and guidance for these services to help team members effectively manage these risks.
		1.2	Standard not met	The pharmacy does not have a process or schedule for completing audits for its supply of medicines against prescriptions from a third-party online private prescribing service company. It does not complete any audits of prescribing and dispensing and so, it cannot effectively identify any instances of inappropriate supply.
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 not all met	4.2	Standard not met	The pharmacy does not have adequate safeguards in place to ensure people receive medicines via a third-party online private prescribing service which are safe and suitable for them to use. It does not always make sufficient checks to ensure medicines are clinically suitable to dispense, this includes for salbutamol inhalers. And it does not review the interventions it makes to ensure dispensing for third party prescribing services is done safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not appropriately manage all the risks associated with supplying medicines to people via a third-party online private prescribing service. It has no documented risk assessments and insufficient written guidance and procedures for dispensing medicines for this service. The pharmacy does not complete any audits or monitor its supply of medicines through the service to ensure people receive medicines which are suitable and safe for them to take. The pharmacy manages its NHS services safely and it provides the team with a set of written instructions to support them to safely manage these services. They keep people's sensitive information secure, and they are adequately equipped to safeguard the health of vulnerable adults and children. The pharmacy has a process for team members to record mistakes made during the dispensing process. And they make changes to the way they work to improve patient safety.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) for its NHS services. These were instructions designed to support the team in safely undertaking various processes. For example, the dispensing of prescriptions and complying with responsible pharmacist (RP) legislation. Team members were required to sign a sheet to confirm they had read and understood the SOPs which were relevant to their role and each team member had signed the sheet. The SOPs had been provided by a third-party and were scheduled for review periodically to ensure they continued to accurately reflect the pharmacy's processes. The current versions were prepared in December 2022 and included a documented, scheduled review date of January 2025

The pharmacy dispensed a significant proportion of prescriptions it received for a third-party online private prescribing service. The service was accessible via the third-party company website. The pharmacy didn't have a complete set of SOPs for the service. This included there being no SOPs relating to the management of continual monitoring of treatment for people on long-term conditions and for the labelling, dispensing, and checking process. The pharmacy hadn't completed written risk assessments for this service, including for each condition and treatment supplied. It hadn't considered completing risk assessments for new treatments/conditions or for unlicensed products or indications. So, there was no documented risk ratings or actions required to mitigate identified risks. The pharmacy's superintendent pharmacist (SI), had identified some risks and the pharmacy had limited the conditions it supplied treatment for. For example, the pharmacy did not supply GLP-1 agonists for weight loss or provide treatment for raised blood pressure. The SI explained they did not feel fully confident the service would allow the pharmacy to appropriately manage people's ongoing progress with treatment for these conditions remotely. The SI demonstrated the process of rejecting prescriptions that were issued for these conditions. As these risk assessments were not documented they were not available for team members to reference. This increased the risk of the pharmacy dispensing medicines for these conditions. The SI had not completed a written risk assessment before starting dispensing for the third-party online prescribing service company and had not documented due diligence checks as part of this. The SI was unsure if the prescribing service was registered with an independent regulator. However, the SI completed weekly checks of each prescriber's registration with the General Medical Council. The pharmacy retained records of these checks.

Team members did not have access to documented prescribing policies, to support them in making decisions about whether maximum quantities and frequencies of supplies were in line with the policies.

The SI explained he had verbally communicated details of maximum quantities and frequencies with team members, including locum pharmacists. For example, if people were prescribed more than three salbutamol inhalers over a three-month period, their prescriptions were to be rejected and sent back to the prescribing service. The SI accepted that it was important for documented policies to be made available to the team, particularly as the pharmacy was scheduled to use a wider pool of locum pharmacists who may not be familiar with dispensing prescriptions issued by the prescribing service. Following the inspection, the SI provided documented policies, but these had no reference to the pharmacy or the online prescribing service, no version control and there were no details of who had created them or when they were scheduled to be reviewed to ensure they remained accurate. Additionally, it was not clear if any formal guidelines had been used to determine the set quantities and frequencies and ensure they were evidence based and appropriate. The pharmacy didn't have guidance or an SOP to direct team members when interventions were required, when referral back to the prescriber was necessary and when prescriptions should be rejected. There was no documented process regarding recording interventions.

The pharmacy did not have a process in place to identify audits to complete, and it had not completed any audits of prescribing or supplies of medicines against prescriptions received from the third-party online prescribing service company. There was no process to identify instances where the pharmacy may have supplied medicines via the prescribing service that were outside of the parameters of its prescribing policies. And so, it may have missed the opportunity to identify instances of inappropriate prescribing or inappropriate supplies of medicines it made.

The pharmacy had a process to identify and record any errors made during the dispensing process, known as near misses. The pharmacist informed the person responsible for the error and asked them to rectify the mistake. The pharmacy had a paper near miss log for team members to use to record details of each near miss. The log had sections to record details such as the type of near miss and the reason it might have happened. The RP admitted that the team had not been consistent in recording near misses and so it may have missed out on the opportunity to spot any trends or patterns. Team members demonstrated some actions taken to reduce the risk of similar near misses from recurring. For example, the team had separated medicines that has similar names or similar looking packaging such as different strengths of levothyroxine. The pharmacy had a digital system to record and report dispensing errors that had reached people. Records of such incidents were retained in the pharmacy and reported to the SI. The pharmacy had a complaints procedure and welcomed feedback from people who used the pharmacy. The complaints procedure was outlined on the pharmacy's website. It included details of how people could raise a complaint directly with the pharmacy and details of the NHS complaints reporting procedure.

The pharmacy had current indemnity insurance. It was displaying a RP notice with the correct details of the RP on duty during the inspection. The pharmacy kept accurate records of private prescriptions issued by locally based prescribers. However, during the inspection, team members were unable to access a private prescription register that detailed supplies of medicines to people who had been issued with private prescriptions via the online private prescribing service. Following the inspection, the SI provided electronic data of supplies against these prescriptions which met the requirements for private prescription records. The pharmacy held complete controlled drug (CD) registers. Running balances of CDs were checked each week by the SI to ensure they were accurate. The pharmacy held a record for CDs that had been returned to the pharmacy by people for destruction. The balance of two randomly selected CDs were checked during the inspection. Both balances matched the physical quantity of CDs stored in the pharmacy's CD cabinet. The pharmacy kept complete records of supplies of unlicensed medicines.

Team members were aware of the importance of keeping people's private information confidential. The

team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate container to avoid a mix up with general waste. The waste was periodically destroyed using a shredder. The pharmacy held a procedure to help the team raise concerns about safeguarding of vulnerable adults and children. The SI and the RP had completed training on the subject. Other team members had not completed formal training but confirmed they had discussed the importance of being able to recognise situations that may require reporting. Team members described hypothetical safeguarding situations that they would feel the need to report. They explained they would discuss any potential concerns with the RP or SI before attempting to report the concern. Team members were aware of how to access the contact details of the local safeguarding teams. The pharmacy did not have a specific procedure in place to support the safeguarding of people who did not live locally and received medicines via the private online prescribing service.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs a suitable number of team members to manage the pharmacy's workload safely. The pharmacy supports its team members to complete qualification training courses. And they can provide feedback on the pharmacy's services to help improve service delivery.

Inspector's evidence

At the time of the inspection the RP was a locum pharmacist who had been working full-time at the pharmacy for several months. The RP was being supported by the SI who worked at the pharmacy part-time, a full-time qualified pharmacy assistant and two trainee pharmacy assistants. Team members who were not present during the inspection were a full-time qualified pharmacy assistant and a part-time delivery driver. The SI had recently completed a review of the pharmacy's staffing profile. Following this review, the pharmacy had increased the number of hours some team members were contracted to work as the pharmacy had increased the number of care homes it was supplying medicines to. Throughout the inspection, team members were observed working efficiently. Team members were supporting each other in completing various tasks. They could cover each other's absences by working additional hours if required, however team members explained this was not common as they felt they had enough team members to efficiently manage the workload.

The pharmacy did not have a formal training programme in place to support qualified team members to update and refresh their knowledge and skills. However, they engaged in ad-hoc training when required. For example, they read pharmacy related press material and received training time to read SOPs within the first few months of starting employment. Team members enrolled on training courses received protected training time each week to support them in completing their course. A trainee pharmacy assistant described how they had recently received training on the use of proton pump inhibitors. Team members engaged in an informal appraisal process each year. This was in the form of a one-to-one discussion between the team member and the SI. Team members explained how they would raise any concerns with the RP or SI and felt comfortable providing feedback to help improve the pharmacy's services. The team was not set any specific performance-related targets to achieve.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are well maintained, secure and kept hygienic.

Inspector's evidence

The premises were closed to the public, which meant people didn't visit the premises to access services due to its distance selling NHS contract. The premises were spread over two floors. It was professional in appearance, spacious, well maintained and kept clean and hygienic. The first floor of the premises included a spacious dispensary used for dispensing prescriptions and the storage of stock and dispensed medicines. There was a small office used for storing documents and for team members to complete administrative tasks. The ground floor of the premises was used to store excess stock and dispensing private prescriptions issued by the third-party online private prescribing service. All areas of the premises were kept organised throughout the inspection.

All areas used to dispense medicines were kept organised with baskets containing prescriptions and medicines awaiting a final check stored in an orderly manner. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final check of prescriptions. This helped reduce the risk of mistakes being made within the dispensing process. The pharmacy had ample space to store its medicines. Floor spaces were kept clear from obstruction.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not have adequate safeguards in place to ensure people receive medicines via a third-party online private prescribing service which are safe and suitable for them to use. They make regular interventions of inappropriate prescribing. But they don't always undertake sufficient checks to ensure medicines they supply via the third party online prescribing service are clinically suitable for people. The pharmacy manages and delivers its NHS services safely and effectively. And it has some good processes in place to make sure people receive their medicines when they need them. It obtains medicines from appropriate sources and its team undertake checks to ensure medicines are fit for purpose before supply to people.

Inspector's evidence

People contacted the pharmacy via telephone if needed. The pharmacy had a website which listed the pharmacy's services and had a 'contact us' page which detailed the pharmacy's address and telephone number. The main window of the premises displayed a list of services that the pharmacy had previously offered such as vaccinations and COVID-19 testing. Since the pharmacy had stopped providing these services, the team had obscured the list of services to avoid miscommunication. The pharmacy advertised its opening hours on the pharmacy's website. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. The pharmacy supplied patient information leaflets and patient cards with every supply. Team members explained they would contact people in the at-risk group via telephone to discuss the risks of taking valproate and ensure they had sufficient understanding of how to take valproate safely.

A significant number of private prescriptions supplied by a third-party private online prescribing service were dispensed by the pharmacy. The pharmacy used a separate labelling system and software, to those used to dispense NHS prescriptions. The system and software were provided by the prescribing service company. But the system did not, provide any details of any interactions or contraindications between medicines. Records of supplies were retained on the system's electronic patient record. The pharmacy had visibility of medicines dispensed to people via the prescribing service. This included medicines that had been dispensed from other pharmacies affiliated with the prescribing service. Team members used this supply history and the answers people had provided to online consultation questionnaires to help them determine if it was appropriate to dispense the prescription. However, the pharmacy could not confirm if prescribers independently verified information provided within the consultation questionnaires, such as previous medical history and diagnosis. They kept records of instances where the team had rejected a prescription. For example, if supplying the medicine would result in the person receiving an excessive quantity of medicines based on the prescribing policies maximum limits and frequencies. The pharmacy had rejected prescriptions on over 250 occasions in the previous three months but had not completed an analysis of these interventions to determine if prescribing for certain conditions/treatments was safe and appropriate.

The SI was aware of the system the prescribing service used to verify a person's identity (ID) before they were able to access the service. The SI explained they had asked the prescribing service for a demonstration of how the system worked to satisfy themselves that the system was robust. Therefore, the pharmacy relied on the prescribing service to complete ID checks.

Following the inspection, the inspector reviewed data of supplies made for salbutamol inhalers and medicines for erectile dysfunction that the pharmacy had dispensed between August and October 2024. These prescriptions accounted for a significant proportion of the prescriptions the pharmacy dispensed from the prescribing service. The data showed that the pharmacy had mostly, supplied medicines within the prescribing policy's set parameters of maximum quantities and frequency. However on some occasions, the pharmacy had supplied salbutamol inhalers to people outside of these boundaries and there had been no intervention for a review of their condition. The pharmacy did not have access to information such as if the person's asthma/COPD was well controlled, if their condition was being monitored, or whether they were prescribed any other medicines to support the management of their condition. For example, a preventer inhaler. This made it difficult to know if these supplies were appropriate.

Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to highlight to the RP the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail 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. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. People were not always required to provide confirmation of receipt of delivery such as a signature. The team accepted this may make it difficult for them to resolve a query and explained they would review the process following the inspection. Deliveries for medicines dispensed against NHS prescriptions were almost always for people who lived locally and so these deliveries were completed by the pharmacy's delivery driver. If the driver was unable to make a successful delivery, for example, if the person was not present at the delivery address, the driver posted a note explaining that the pharmacy had attempted delivery and to contact the pharmacy to rearrange delivery at a suitable time. The driver attempted to delivery medicines up to three times before contacting a team member attempted to contact the person via telephone. If the person could not be reached, the team returned the prescription to the prescriber and informed them of the situation. Medicines supplied via the third-party prescribing service were delivered via a specialist courier. These deliveries were tracked throughout the delivery process.

The pharmacy supplied several people living in their own homes and people living across several local care homes, with medicines dispensed in multi-compartment compliance packs. Team members spread the workload evenly over four, colour-coded weeks. Prior to beginning the dispensing process, they checked prescriptions to ensure they were accurate. They kept electronic records of any changes that prescribers had authorised. For example, if a medicine's strength was increased or decreased. They recorded the date of authorisation and the name of the prescriber. The packs were supplied with patient information leaflets, and they were annotated with descriptions of the medicines inside.

The pharmacy obtained medicines from recognised suppliers. Team members described how they checked the expiry date of the pharmacy's medicines every three months. The team were unable to demonstrate any records to confirm this process had been completed. However, no out-of-date medicines were found following a check of approximately 20 randomly selected medicines. Team members highlighted expiring medicines using dot stickers, to help identify which medicines to use first when dispensing. The pharmacy used a fridge for storing medicines that required cold storage. The team recorded the fridges' temperature ranges of each fridge daily which showed it was operating correctly. The pharmacy received drug alerts via email. Team members actioned the alerts as soon as possible but didn't keep a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment in a way to protect people's confidential information.

Inspector's evidence

The pharmacy both electronic and hard copies of several reference sources, including the British National Formulary (BNF) and BNF for Children. It used a range of CE marked measuring cylinders for preparing liquid medicines and there were several clean tablet/capsule counters for team members to use. Separate cylinders were used to dispense water and medicines. This helped reduce the risk of contamination. All computers were password protected to prevent unauthorised access.

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.