

Registered pharmacy inspection report

Pharmacy Name: Mail My Meds, Nationwide Health Direct Ltd, Unit 1, Ground Floor, Karmjit House, Balliol Business Park, Newcastle Upon Tyne, Tyne and Wear, NE12 8EW

Pharmacy reference: 9011560

Type of pharmacy: Internet / distance selling

Date of inspection: 08/03/2022

Pharmacy context

This is a distance selling pharmacy situated in a unit on a business park in Newcastle, Tyne and Wear. It dispenses NHS and private prescriptions. And provides a Covid-19 vaccination service on site and in an associated premises next door. 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.

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	2.2	Good practice	Members of the pharmacy team are well supported with on-going training to keep their skills and knowledge up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a good range of services to meet people's needs and these are well signposted on the pharmacy website and through leaflet drops.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy identifies and manages risks with its services. And it effectively manages the risks with infection control during the pandemic to help keep members of the public and team members safe. It maintains the records it needs to by law and correctly secures people's private information.

Inspector's evidence

This was a new distance selling pharmacy that was run by the Superintendent (SI) with assistance from a fully time dispensary assistant. The pharmacy had appropriately addressed the risks of managing its services during the Covid-19 pandemic. The layout of the pharmacy helped the team to socially distance. A sign outside of the pharmacy advised people to wear a face covering when entering. And both team members continued to wear type IIR face coverings whilst working.

The pharmacy had a set of standard operating procedures (SOPs), that had been written in March 2021. These had an index and the SI had tailored these to reflect current practice. The SOPs covered various processes such as dispensing and the requirements of the Responsible Pharmacist regulations. Both members of the pharmacy team had read and signed the SOPs. The pharmacy had a process in place to record and report near miss errors made when dispensing. The pharmacy team kept a near miss record and advised the inspector that because of the numbers of prescriptions dispensed there had only been one near miss recorded since April 2021. The entry lacked detail of how the error had occurred and what the team had done to mitigate the risk. The dispensary assistant explained that a contributing factor to the error had been the unusual pack size. And this had been discussed at the time. No notes had been made of these discussions. Unfortunately, a similar incident had occurred and the incorrect quantity had been supplied to the patient. The pharmacy used the NPA electronic recording system to document details of the dispensing error. Both members of the team demonstrated a good understanding of risk and showed the inspector various medicines with similar names that had been separated on the shelves. The notice board displayed information about learning from controlled drug (CD) incidents and information about look alike sound alike drugs to remind the team to take extra care when dispensing such items. The team had a monthly near miss and error review process but this had not yet been used due to the very low error rate. The pharmacy had a complaints procedure and this was clearly laid out in the pharmacy leaflet along with the services the pharmacy provided. The details were also displayed on the pharmacy website.

The pharmacy displayed a valid NPA indemnity insurance certificate. A Responsible Pharmacist (RP) notice clearly displayed the name and registration number of the RP on duty as did the website. The pharmacy kept a RP record, and it was complete. The SI checked CD running balances weekly. The controlled drug (CD) cabinet held a small range of CDs. A random balance check of an item in the CD cabinet tallied with the CD register quantity. The pharmacy had a procedure and a marked file to keep records of unlicensed special medicines together. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. And team members understood the importance of keeping people's private information secure. The SI segregated confidential paperwork for shredding off site. The pharmacy had safeguarding procedures for the team to follow and team members had access to contact numbers for local safeguarding teams should they need them. The SI had completed Level 3 training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). The team member who delivered medication

to people at home reported any concerns to the pharmacist. The SI contacted vulnerable people for example those who had been in hospital or elderly people who were isolated to check if they had the medication they needed and were managing.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs a small, dedicated team of people who have the appropriate skills and knowledge to deliver its service effectively. And it is good at training and developing its team members to provide a wide range of services to meet people's needs. They do ongoing training and are given time set aside at work to complete it.

Inspector's evidence

The pharmacy team on the day consisted of the SI, one full time dispensary assistant and a delivery driver who worked part time hours. The team managed the workload comfortably. When the SI ran Covid-19 vaccination clinics extra trained staff assisted. The SI and dispensary assistant worked well together and were always looking for ways they could make changes to improve the service the team provided. The SI advised that they had time available to provide additional services and had completed training to provide a range of services including smoking cessation, flu vaccinations, Covid-19 vaccinations, and weight loss services. The team had also completed NHS England learning for Health Care training units such as childhood and adult obesity and making every contact count. The dispensary assistant had enrolled on an NVQ 3 course, and the SI supported her with her training. The delivery driver had good knowledge of the local area and when asked about the delivery process, particularly in relation to CDs, he explained the system he used to ensure medicines were supplied to the right people. The dispensary assistant advised that if she had concerns, she would discuss it first with the SI and would then follow the whistle blowing policy. She found the SI approachable and felt comfortable about making suggestions on how to improve the pharmacy and its services. She particularly enjoyed going in to care homes and helping them with issues such as managing the racked multi-compartment patient packs. And safe storage of medicines. Team members had regular six-monthly reviews where what had been achieved was discussed and next steps.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, hygienic, properly maintained and provides a good environment for the provision of healthcare.

Inspector's evidence

The pharmacy had been fitted out to a good standard. The benches and floor areas were clean and clutter free. The SI had designed the pharmacy so that the team had separate areas for different processes such as dispensing and checking. This helped the team to establish a smooth workflow. The pharmacy was well lit and had air conditioning. The dispensary had a sink with hot and cold running water for the team to use while dispensing. The team tearoom and toilet facilities each had washing facilities. A reception area to the front had a good-sized seating area. The generously sized consultation room had a computer desk, and chairs. And it was accessible for people from the waiting area. The team had an entrance from the dispensary.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a good range of services that are easily accessible and suitably support 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 appropriately.

Inspector's evidence

The pharmacy advertised its services through its website and leaflet drops. And people could access the pharmacies services by telephone or from the information on their website. The pharmacy website outlined the pharmacy's opening hours and the services provided. And it had links to NHS A-Z of Medicines and NHS A-Z of Medical Conditions. The website was clear and concise and easy to navigate. The pharmacy team provided 4,800 Covid-19 vaccination to date.

The SI and dispensary assistant used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. They used separate areas of the benches to carry out the dispensing process and final checks of prescriptions. The driver used a bench to the side for deliveries. A handful of patients received their medication through Royal Mail 48 hour tracked delivery. For fridge lines the pharmacy used Royal Mail guaranteed delivery in 24 hours tracked. The team used special ice packs and wool packaging to ensure that fridge items remained cool. The pharmacy had a written procedure for postal deliveries and kept audit trails for such deliveries.

A check of completed prescriptions confirmed that the dispensing labels had been initialled. This provided an audit trail to indicate who had dispensed and checked the item. The team contacted people via telephone to provide information about their medicines. For example, if they had a new medicines or had been prescribed high risk medicines that required ongoing monitoring. A team member contacted warfarin patients to find out when they last had their bloods checked and warfarin levels. But they did not enter the information onto the patient's medication record. The SI and dispensary assistant demonstrated their understanding of the pregnancy prevention programme for people who were prescribed valproate. The pharmacy supplied medicines in multi-compartment compliance packs to people on request. The team had a tracker sheet so team members could see what stage each patient's pack was at in the process. The team supplied patient information leaflets monthly in week one of the process. And this was highlighted on the sheet. Each patient had a medication record sheet with a section to note any changes. The team included tablet descriptions so that people could identify each medicine in the pack.

The team kept stock neat and tidy on pharmacy shelving. The pharmacy had a controlled drug cabinet with adequate space to segregate expired stock and items awaiting destruction. The pharmacy purchased medicines and medical devices from recognised suppliers. The SI confirmed that date checking had been done regularly and provided the date checking records to show this. The team highlighted short dated items so they could be identified easily and removed from the shelves a month before expiry. Sampling of three areas in the pharmacy showed that items were within the manufacturer's expiry date. Team members used a medical grade fridge to keep stock at the required temperature. And used plastic bags for fridge and CD lines, so people could easily check the contents before supply. Team members monitored and documented the temperature of the fridge to ensure they were operating within the accepted range of 2 to 8 degrees Celsius. The pharmacy had medical

waste boxes and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy received electronic notifications of drug alerts and recalls. So far none of the alerts had been applicable to the stock they held.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the required equipment for providing its services. It's team members use this equipment appropriately and in a way which protects people's privacy.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available. Written reference resources included the British National Formulary (BNF). Pharmacy team members had access to the internet. Computers were password protected, and computer monitors faced into the dispensary. The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. The team had separate equipment available to them for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Both team members had NHS smartcards. And had a range of consumables to dispense medicines into compliance packs. Large baskets kept people's medicines and compliance packs separate.

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.