General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medplus Pharmacy, Unit 5, Upminster Trading Park, Warley Street, Upminster, Essex, RM14 3PJ

Pharmacy reference: 9011742

Type of pharmacy: Internet / distance selling

Date of inspection: 26/07/2023

Pharmacy context

This pharmacy supplies its services at a distance, and it is located in an industrial park. The pharmacy dispenses NHS prescriptions which are mainly supplied to people living locally. It offers the New Medicine Service (NMS) and a delivery service.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It keeps the records it needs to keep by law, and these are largely kept accurate and up to date. And it protects people's personal information appropriately. People can provide feedback about the pharmacy's services.

Inspector's evidence

Standard operating procedures (SOPs) were available. These were generic SOPs the responsible pharmacist (RP) had obtained. The SOPs were specifically designed for distance selling pharmacies. Team members including the driver had read SOPs relevant to their roles.

Risk assessments had been completed before the pharmacy had opened, the pharmacy had started trading in December 2022. The RP planned to review the risk assessments within the next few months. But he said there had not been any major changes.

Dispensing mistakes which were identified before the medicine was handed out (near misses) were recorded on a log, these were mainly from the time period that the dispenser had been working and were mainly due to the unfamiliarity of the workspace. The RP reviewed the near miss logs from time to time. There had not been an instance where the wrong medicine was handed to a person (dispensing errors). The RP described the steps he would take if there was a dispensing error and would report these on the National Reporting and Learning System (NRLS). The pharmacy team also flagged important information about how people took their medicines on the individual's electronic record. The RP gave an example of how ramipril was usually taken in the morning, but someone had been advised to take their dose in the evening by the hospital. Once the team had been made aware of this, they had flagged it to ensure this was dispensed correctly in the multi-compartment compliance pack.

The pharmacy had current professional indemnity insurance. It had a complaint procedure and a complaints section on the website that people could use. The RP said there had not been any complaints since they had opened. The correct RP notice was displayed.

The pharmacy had not dispensed any private prescriptions, made any emergency supplies or supplied any unlicensed medicines. Records for controlled drug (CD) were well maintained. The RP record was generally kept in line with requirements, but pharmacists were nor regularly signing out. The RP had not been present at the pharmacy initially and there was also no record of any absence, there had been no other team member present in the pharmacy during this period. A random check of a CD medicine complied with the balance recorded in the register. A register was available to record CDs that people had returned.

The pharmacy had an information governance policy and the driver had been verbally briefed on data protection. The premises were not physically accessible to members of the public, except for those accessing prebooked travel vaccines. A shredder was available for confidential waste. Computers were password protected and the RP had an NHS smartcard. The RP had access to Summary Care Records (SCR) and consent was gained verbally.

The RP had completed the level two safeguarding training course. The RP was aware of where the contact details could be found for local safeguarding boards. The driver had been verbally briefed about safeguarding, the RP said he would look into getting him to do level 1 training course.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. Team members discuss any issues as they arise. The pharmacy has support staff available to help should the need arise.

Inspector's evidence

The pharmacist was the only person present during the inspection and predominantly worked alone. The pharmacy employed a delivery driver who worked at the weekends or would come in if there were any urgent deliveries. Other deliveries were done by the RP. The RP said he was able to cope with the current workload. A trained dispenser occasionally came to help. As did a pharmacist. A trainee dispenser occasionally came to help with the admin and cleaning. As the team comprised only of the pharmacist and driver things were discussed as they arose. The RP felt there were currently enough staff for the workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are generally clean and secure. And its website gives people information about who is providing its services.

Inspector's evidence

The pharmacy was situated on the first floor of a unit in an industrial park. The premises consisted of two rooms. The largest room was used as the dispensary and there was a glass wall separating the second room which was used as a consultation room to provide face-to-face services. Medicines were stored on shelves and there was a counter with the computer system and space for dispensing. The fridge was kept in the consultation room and the sink was also in this room. Cleaning was done by the pharmacist and the pharmacy was clean. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare.

The pharmacy had its own online website (https://medpluspharmacy.co.uk/). This website gave clear information about the pharmacy's opening times, how people could complain, the pharmacy's contact details and GPhC registration information and of the pharmacy owner and RP. There were a limited number of over-the-counter medicines which could be purchased via the website. There were no ‘Pharmacy’ only (P) medicines and there had not been any over the counter sales via the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from reputable sources and manages them appropriately so that they are safe for people to use. Team members take the right action when safety alerts are received, to ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was closed to people physically accessing it, except for people attending for prebooked vaccination appointments. Services provided were advertised on the pharmacy's website. Since opening the pharmacy had seen approximately 15 people for the private travel vaccines. The pharmacy mainly delivered medicines locally and to people living nearby. The RP described how currently people using the pharmacy were friends and family. The RP was aware of the need to signpost people to other services and other pharmacies if needed. The pharmacy had not had any requests from people whose medicines could not be delivered. The RP was a pharmacist independent prescriber but was not providing any prescribing services from the pharmacy.

Prescriptions were received by the pharmacy electronically. The RP printed out received prescriptions, prepared labels, and ordered stock. Once dispensed these were then left aside and checked the next day by the RP, previously on some occasions a second pharmacist would check. Once prescriptions were ready the RP called people to inform them and arranged a suitable time for delivery. Dispensed and checked-by boxes were available on labels, these were used to create an audit trail. Baskets were used to separate prescriptions, preventing transfer of items between people. When prescriptions were received for people who had not previously used the pharmacy, the RP called to confirm with them that they had meant for the prescription to be sent to the pharmacy and were expecting the medicines to be delivered.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. The pharmacy did not have anyone who fell into the at-risk group. The RP was aware of the additional checks which needed to be completed for people taking medicines which required ongoing monitoring.

Some people's medicines were supplied in multi-compartment compliance packs. People usually contacted the pharmacy when they were due to run out and prescriptions for these were ordered by the pharmacy. The pharmacy also kept a record of when packs had been delivered. On receiving the prescriptions these were checked for any changes or missing items. The pharmacy's computer system highlighted any new medicines or changes when labelling. Packs were prepared and sealed by the RP, on some occasions the dispenser helped. Epilim was placed inside compliance packs for one person. This medication had limited stability once it was taken out of its original packaging. The RP confirmed that the Primary Care Network (PCN) pharmacist had requested for the medication to be placed inside the pack to ensure it was taken correctly. Assembled packs were labelled with product descriptions and mandatory warnings. Patient information leaflets (PILs) were not routinely supplied with the packs. The RP agreed to ensure these were provided monthly.

The RP counselled people on how to use their medicines depending on what was being supplied. People

were counselled on the use of their medicines face to face when the RP delivered medicines. The RP tried to visit people at least once every couple of months. People could contact the pharmacy via the website or telephone. And some people called the pharmacy to check any symptoms or issues.

PGDs were all provided via CityDoc. People booked services via the website. The RP mentioned that there was not a large demand for the service. The RP had attended face-to-face training to be able to provide these services.

Deliveries were carried out by the driver and RP. In the event that someone was not at home, medicines were returned to the pharmacy. Although the RP said this had not happened as people were generally called before delivery was attempted. Signatures were not obtained, and the RP planned to buy a delivery record book specifically for CDs. In the event that any medicines needed to be sent outside of the delivery area, the pharmacy would use Royal Mail. The RP had also spoken to a company about packaging for cold chain delivery if needed.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. CDs were kept securely. The pharmacy held very limited stock. Medicines were ordered as they were required for prescriptions. Expiry dates were checked as part of the dispensing process and the RP checked dates from time to time. There were no expired medicines found on the shelves checked. Out-of-date and other waste medicines were disposed of in the appropriate containers which were kept separate from stock and collected by a licensed waste carrier.

Drug recalls were received by email. The RP checked stock, but the pharmacy held very limited stock and the RP said the pharmacy had not had stock for any of the recent recalls. Drug recalls were printed and filed once checked.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services.

Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. Up-to-date reference sources were available including access to the internet. The pharmacy had a medical fridge of adequate size. A blood pressure monitor had been taken home by the RP. This was new and plans were in place to calibrate it. Computer screens were password protected.

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.