

# Registered pharmacy inspection report

**Pharmacy Name:** Medcann Pharmacy, Unit G114, Oxgate House,  
Oxgate Lane, London, NW2 7FS

**Pharmacy reference:** 9011824

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 16/08/2024

## Pharmacy context

This is a new, private pharmacy in a business park in northwest London. It supplies medicines against private prescriptions to people who live in the United Kingdom (UK). It does not have an NHS contract to supply medicines against NHS prescriptions. The pharmacy does not provide any other online services at the time of this inspection.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy generally identifies and manages the risks associated with providing its services. It risk-assesses its processes and updates its standard operating procedures (SOPs) as processes develop. But it does not formally document the risk assessments. People who use the pharmacy can leave feedback to help it do things better. The pharmacy keeps the records it needs to by law to show how it supplies its services and medicines safely. It keeps people's private information safe and understands its role in protecting vulnerable people.

### Inspector's evidence

The pharmacy was in a quiet location with minimal disturbance when dispensing and the responsible pharmacist (RP) attributed this to the lack of near misses and dispensing incidents to date. There was a process in place to deal with mistakes and the RP had a near miss log to be reviewed regularly although no near misses had been recorded to date. Following a dispensing incident, the RP would follow the protocol for reporting the details to the Controlled Drug Accountable Officer (CDAO).

The pharmacy had a range of documented standard operating procedures (SOPs) in place to provide guidance on its services. They were specific to the nature of the pharmacy's business and they were updated as the process developed. The responsible pharmacist (RP) who was also superintendent pharmacist (SI) described risk assessing the service and its component processes such as checking people who accessed the service were genuine patients, and checking the clinic and prescriber. The RP had completed risk assessments for ordering the medicines, stock management and delivery of dispensed medicines. But the RP had not completed documenting all the risk assessments.

The RP worked with the prescribers in three clinics. The FP10PCD prescriptions were posted or delivered to the pharmacy. If people contacted the pharmacy direct to obtain medicines they were signposted to the designated clinics where they could have a consultation with doctors or pharmacists. If a medicine was approved the prescription could be sent to a pharmacy to be dispensed and delivered to the person. On receipt of the prescription, the RP checked people's identification by asking them for their driving licence and a utility bill which also confirmed their address if it was the same as their preferred delivery address. And the RP checked the patient address online to make sure it was a real address. The person's consent was recorded including consent for the RP to contact their usual doctor or surgery. The identity of the clinic was confirmed and its registration status. For example with the Care Quality Commission (CQC). And the authority or credentials of the prescriber to prescribe these medicines such as their General Medical Council (GMC) registration. The RP had emailed one clinic to establish the processes followed by their independent prescribers (IPs).

On receipt of the prescriptions, the RP checked prescriptions and the date they were issued to make sure they were valid and there was enough medicine to cover the treatment period. Any red flags were included with the notes. The RP created a prescription log to monitor the prescription journey. Sometimes prescriptions were post-dated and not dispensed until requested by people which would then trigger an invoice for payment. At the time of the inspection visit, the RP was trying to obtain access to the NHS National Care Records Service (NCRS) for the purposes of verifying people's medical history such as other medicines they were already taking and potential interactions. And following the

visit, the RP was able to report progress with accessing the NCRS. This was more relevant to people who were regularly prescribed the medicines for pain rather than for other conditions. The RP documented any checks which were made with the prescriber to create an audit trail. And he recorded people's consent to share information with their usual GP. The RP reported that people were generally willing to share information with their GP but if there were concerns the RP would liaise with the prescriber who would have assessed the person already. And ask the person to share the information (patient access/NHS record screen shot) with the pharmacy, if they are not happy to share with their GP and explain the need to know for clinical reasons to ensure safe dispensing for them.

The RP worked closely with the clinics and sat in multi-disciplinary teams regularly to enhance his knowledge. However, people took their prescriptions to their own choice of pharmacy. Guidance was given to record interventions in full on the patient medication record (PMR) . People were asked for their feedback on the website. And there was a section on the website inviting feedback and complaints in more than one place.

The RP processed prescriptions in batches through the PMR and entered any relevant information. He generated dispensing labels and address labels, and then dispensed medicines into a drop box along with the prescription and relevant labels. Medicines were dispensed in their original packaging. There were designated dispensing and checking areas where prescriptions were assembled before being placed in appropriate packaging to which the address label was attached. Then finally completed packages were placed in the delivery area for dispatch with the courier. The RP completed a dispensing audit trail identifying who dispensed and checked each item. And the courier and people receiving it were required to inform the pharmacy immediately if any part of the package went missing while making a delivery. The pharmacy computer had a three-way chat function so members of the team including a locum pharmacist could communicate easily and guidance was given to keep contemporaneous notes of items discussed. The person had a copy of their prescription in case there were future queries.

The pharmacy had insurance in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that identified who the responsible pharmacist (RP) was and the RP record was completed showing when the RP was present. The RP record book was not bound as required but the same RP was generally signed in. Following the visit, the RP replaced the existing record with a bound RP record and provided photographic evidence. The pharmacy maintained a CD register but it was not a bound register. So the RP immediately replaced the register with newly purchased CD inserts, closed the existing registers and transferred the balances to the new bound CD inserts as of 21/8/24 and provided photographic evidence. The pharmacy maintained records for supplies of private prescriptions and special unlicensed medicines. Following the visit, the RP designed a template to complete with patient and prescriber information and attach to the Conformity Documents.

The RP had trained in Information Governance via NHSE elearning for health care (elfh). The pharmacy was registered with the Information Commissioner's Office (ICO). Its website explained to people how their personal information was gathered, used and shared by the pharmacy and its team. And the pharmacy had arrangements to make sure confidential information was stored and disposed of securely. Members of the pharmacy team had read and signed a confidentiality agreement. The (RP) had trained to level 3 in safeguarding and reported that to date there had been no safeguarding incidents. The SI was signposted to the NHS safeguarding App.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacist easily manages the workload. He actively participates in a multi-disciplinary team to keep himself up to date. And he belongs to a clinical medical group.

### Inspector's evidence

The pharmacy team consisted of the regular pharmacist who was also the superintendent pharmacist. And another person who carried out administrative tasks. Due to the pharmacy's volume of dispensing, there was enough staff to manage the workload and the pharmacy was up to date with this. As a small team, communication was verbal.

The RP had a role in a multi-disciplinary team (MDT) and sat in on consultations in pain and psychiatry. And he was a member of a clinical medical group which supported clinicians prescribing medicines safely and effectively medicine to people living with chronic conditions.

The RP had updated training in Information Governance and safeguarding level 3 via NHS elfh website. The RP by speaking to colleagues with distance selling pharmacies in other specialist areas. And referred to GPhC guidance. And read up on information related to some of the clinical aspects eg terpenes that could be benefiting other patients.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of its services. The design and layout of the pharmacy mean that people could have a private phone conversation with the pharmacist. The pharmacy prevents people accessing its premises when it is closed so that it keeps people's private information and its medicines safe.

### Inspector's evidence

The pharmacy premises were inside a unit on a business park, which had staff facilities. The pharmacy was in a secured area on the mezzanine floor within the larger unit and only designated people had access to it. The pharmacy was clean and tidy. It had enough workspace for dispensing, a suitable amount of space for storing medicines and for holding any necessary equipment. The pharmacy was air-conditioned with sufficient lighting.

The website was accessed via <https://medcannpharmacy.co.uk/> and it had details of other pharmacies dispensing similar medicines. People could access the pharmacy out of hours. It included information in line with the GPhC guidance for pharmacies providing services at a distance including on the internet. Such as pharmacy contact details, SI details and how to complain. And the opening hours were amended following the visit. People could sign up to access information about the pharmacy, what to do with their prescription, leave feedback.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy generally provides its services safely and effectively. The pharmacy sources its medicines from reputable suppliers and stores them securely at the right temperature to help make sure they are fit for purpose. And it ensures assembled prescriptions are delivered safely to the right people. The pharmacy knows what to do if it receives a recall about one of its medicines.

### Inspector's evidence

The pharmacy website displayed information that helped people contact the pharmacy. The RP could print large font labels which were easier to read if needed. The pharmacy currently supplied specific CDs against private prescriptions they received. Relevant checks were made to ensure prescribers had appropriate registration and qualifications. People completed the 'patient sign up' or 'register here' section creating an account with the pharmacy through their website. Identity checks were then required by seeing and obtaining nationally recognised photographic ID as well as proof of address via a utility bill which needed to be dated within the past three to six months. The RP checked whether the person had used or taken the medication before, whether they had any allergies and requested details about other medication. Relevant information was recorded on the person's medication record (PMR).

The pharmacy obtained its medicines from licensed suppliers. On receipt of medicines, the RP checked they were from the same batch and had at least six months to one year's expiry date. The RP checked the date on declaration or certificate of conformity (COC) for all specials, unlicensed medicines both on receipt and when dispensed. And completed the patient and prescriber details. Following the visit, the RP created a template to complete with the required information with the conformity documents. The RP cross referenced the delivery note, printed the COC and made appropriate entries in the CD register.

The RP worked with the prescribers in three clinics. The FP10PCD prescriptions were posted or delivered to the pharmacy. On receipt of a prescription, the RP completed administrative tasks first before dispensing. The RP checked the person's identification by asking them for nationally accepted photographic identification such as passport or driving licence and a utility bill which also confirmed their address if it was the same as their preferred delivery address. If possible, the pharmacy obtained the person's consent to contact their GP. And the RP checked the patient address online to make sure it was a real address. The identity of the clinic was confirmed along with its registration status. For example, with the Care Quality Commissioner (CQC). And the authority or credentials of the prescriber to prescribe these medicines such as their General Medical Council (GMC) registration.

The RP checked the prescription was correctly issued and the dose of medicines prescribed was correct. He checked the amount prescribed would cover the treatment period, along with the date of the prescription and the date of the last dispensing. If a prescription was received early the RP contacted the prescriber to check if this was intended. The RP created a log of post-dated prescriptions which was stored securely and when the person contacted the RP to make-up their prescription, this triggered their invoice to be issued and paid. The RP explained that sometimes the person could not pay for the whole amount prescribed at once. So the prescription was endorsed accordingly. The RP completed a clinical check of the person's medical history including other medicines they were taking,

possible interactions and interventions which were documented. Some preparations were suitable for different routes of administration such as sublingually or vaping which required a vaporiser.

The RP dispensed and checked prescriptions in different designated areas of the dispensary and took a mental break between each step in the process. After the final accuracy check of the medicine, it was enclosed and sealed in packaging which protected the contents from being identified. The package was placed in the area for delivery items. A member of the pharmacy team sometimes delivered packages to a local address. The person was contacted to make sure they were in and could sign for accepting the delivery. Some people preferred a Saturday delivery if they were working. The pharmacy had retained historic delivery logs. The pharmacy used a courier for the majority of deliveries which would attempt two deliveries to the same address, was aware of the nature of the medication being delivered and had a secure facility at its depot in which to lock packages for re-delivery following a failed first delivery. The pharmacy could track deliveries and check people's feedback on reliability of the courier. The courier and the person were required to inform the pharmacy immediately if the medicine went missing. The RP reported that to date there had been no incidents involving deliveries.

The pharmacy had not dispensed any prescriptions for sodium valproate or other common higher-risk medicines but the RP was aware of the most recent updates when supplying a valproate or topiramate. Medicines were stored in an orderly fashion and there were no items requiring refrigeration at the time of the visit. The pharmacy had a process for dealing with drug alerts and recalls it received and printed. The RP explained how the pharmacy responded and that he would contact people if they had been supplied the affected stock. There had been no incidents to date which required 'yellow card' reporting but people were advised to tell the pharmacy if they had an adverse reaction to a medicine.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And it makes sure the equipment protects private information.

### Inspector's evidence

The pharmacy had access to the necessary equipment and online resources in line with its dispensing activity. This included appropriately secure storage for its medicines stock. The pharmacy's computer term was password protected. And the confidential waste it produced was stored and disposed of securely.

### 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.