General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: My Pharmacy Online UK Ltd, Unit 9, Sterling Industrial Park, Carr Wood Road, Castleford, West Yorkshire, WF10 4PS

Pharmacy reference: 9011830

Type of pharmacy: Closed

Date of inspection: 01/11/2022

Pharmacy context

This pharmacy provides its services at a distance and physical access to the premises is closed to the public. People can visit the pharmacy website and contact the pharmacy by telephone. The pharmacy's main activities are dispensing NHS prescriptions and delivering medicines to people's homes. It supplies some medicines in multi-compartment compliance packs to help people take their medication.

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
1. Governance	Standards met	1.4	Good practice	The pharmacy proactively seeks feedback from people using its services. And it uses the feedback to enhance the safety and quality of the services provided.
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 suitably identifies and manages the risks associated with its services. It keeps the records it needs to by law and it protects people's private information. The team members actively seek feedback from people using the pharmacy services which they respond well to. They have guidance and training to help them correctly manage safeguarding concerns. And they respond appropriately when errors happen to prevent future mistakes.

Inspector's evidence

The pharmacy had a wide range of up-to-date standard operating procedures (SOPs) to support the safe delivery of its services. An index kept with the SOPs clearly listed the topics covered and where to locate each SOP. The four regular pharmacists had read the SOPs and signed the SOPs signature sheets to indicate they would follow them. A fifth pharmacist who worked occasionally had not signed to confirm they had read the SOPs. The delivery driver was in the process of reading the SOPs relevant to their role.

The pharmacy had a procedure for managing errors identified during the dispensing process known as near misses. And it had a separate procedure for errors that were identified after the person had received their medicines known as dispensing incidents. The pharmacy had a log for team members to record their near miss errors. This showed one entry describing the dispensing of the wrong formulation of a medication. The SI shared this near miss with the team. And discussed with the team how to prevent the error from happening again by double checking the medicine picked against the prescription. The pharmacy website provided people with information on how to raise concerns. The SI sought feedback from the local care teams who'd referred people to the pharmacy and from people who received their medication in compliance packs. So, the team could identify aspects that worked well and where improvements could be made. The SI and delivery driver had changed the delivery times after feedback from people that they'd prefer not to have evening deliveries.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy completed regular balance checks of the CD registers to help identify errors such as missed entries. The pharmacy had a procedure covering information governance and data protection. The pharmacy website displayed details on the confidential data kept and how the pharmacy complied with legal requirements. It also displayed a privacy notice. The team separated confidential waste for shredding onsite.

The pharmacy procedures included safeguarding guidance and details of local safeguarding teams was available. The SI had recently completed appropriate training on protecting children and vulnerable adults. And responded well when concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the qualifications and skills to support its services. The team members support each other in their day-to-day work and trainees are given time to complete their training courses. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services

Inspector's evidence

The Superintendent Pharmacist (SI) and three other pharmacists worked part-time at the pharmacy along with a part-time delivery driver. The pharmacy was recruiting for a dispenser. The delivery driver had been in post over three months and had not worked in a pharmacy before. The driver had recently enrolled onto an appropriate training course and had protected time to complete the training. The SI also provided the delivery driver with training and had regular one-to-one sessions with the driver to discuss their role.

The SI kept his knowledge and skills up to date as part of his professional revalidation. The pharmacists regularly communicated with each other to ensure they had up-to-date information on how the pharmacy was operating. And to share any issues regarding people's medication they all had to be aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are appropriate for the services the pharmacy provides. And the pharmacy is suitably clean, hygienic, and secure.

Inspector's evidence

The pharmacy premises were tidy and hygienic. The team members used separate sinks for the preparation of medicines and hand washing and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The premises had several measures in place to keep the pharmacy secure and to restrict public access during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The team manages its services well and makes sure people receive their medicines when they need them. Team members support people with advice and healthcare information. And they work closely with local health and social care teams to identify how to help people take their medicines safely. They store medicines properly and they regularly carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was closed to the public which meant people could not access the pharmacy premises directly. The pharmacy website provided people with information about the services offered, the operating hours and contact details for the pharmacy. The SI had plans for a blood pressure monitoring service that initially would be offered to people working in the business units close by. The pharmacy had a range of information leaflets from Diabetes UK and the British Heart Foundation that were supplied to people with their medication. The pharmacists spoke to people about their medication when a new medicine was prescribed or there was a dose change. And they asked the delivery driver to advise people to expect the call from the pharmacist. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information they had to provide. The pharmacy had a specific SOP covering valproate and the PPP but it didn't have anyone prescribed the medicine who met the criteria.

The pharmacy provided multi-compartment compliance packs to help five people take their medicines. The SI contacted the local Connecting Care team to advise of the services the pharmacy could provide. This resulted in several people being referred for the pharmacy to provide the packs. Before starting the service the SI arranged a visit to the person's home to discuss their medication and how the packs worked. And followed this up with regular calls to ensure the person was taking their medication correctly. The SI arranged for prescriptions to be sent to the pharmacy a week before the packs were supplied. This gave the team time to deal with any queries and dispense the prescriptions before the person needed their packs. The pharmacy kept a list of each person's current medication and dose times. The team members checked prescriptions against the list and referred to it when dispensing the prescriptions. They recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and they had information about their medicines.

The pharmacists managed the workload so they were usually a week ahead with the dispensing of prescriptions. This enabled one pharmacist to undertake the dispensing process and separate pharmacist to complete the clinical and accuracy checks of the prescription. The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. And it kept a list of each team member's signature against their name to identify who was involved in the dispensing of the prescriptions. A sample of dispensed prescriptions found the team completed both boxes. The pharmacy kept a record of deliveries made to people for the team to refer to when queries arose. The driver asked people to sign for the receipt of CDs.

The pharmacy obtained its medicine stock from several reputable sources. The team members regularly checked the expiry dates on stock and kept a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team members checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team actioned the alert and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people’s confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication and an appropriate pharmacy fridge. The pharmacy computer was password protected and access to people’s records restricted by the NHS smart card system.

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.