General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Med Mart Pharmacy, 2 Imperial Place, Maxwell Road, Borehamwood, Hertfordshire, WD6 1JN

Pharmacy reference: 9011843

Type of pharmacy: Internet / distance selling

Date of inspection: 25/10/2022

Pharmacy context

This is an internet pharmacy in a business centre in Borehamwood in Hertfordshire. The pharmacy operates a distance selling model. The pharmacy dispenses NHS and private prescriptions and provides health advice. It mainly provides services to care and nursing homes and supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include travel, COVID and flu vaccination clinics.

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's working practices are generally safe and effective. It reviews the risks involved in providing its services. The pharmacy has suitable standard operating procedures (SOPs) in place to make sure its team members know how to work safely. The pharmacy can easily show who completed each step of the process of the services it provides. Members of the team keep the records they need to up to date. They manage and protect people's private information and they are trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. During the daily huddle, the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't always fully record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The pharmacy had a complaints procedure and the pharmacist regularly compiled patient safety reviews. The pharmacy manager explained that some groups of medicines such as cytotoxic and calcium products were separated from each other in the dispensary, and this helped reduce picking errors.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the pharmacy team members. They self-tested for COVID-19 if they were unwell and had access to fluid resistant face masks to help reduce the risks associated with the virus. And they washed their hands regularly and used hand sanitising gel when they needed to. The pharmacy risk-assessed its new services and retained documentation for most services in labelled folders. These documents included the standard operating procedure (SOP), patient group direction (PGD), records and yellow card reporting system. The pharmacy team could work to a business continuity plan to ensure services were not disrupted in an emergency. The pharmacy manager described audits which were completed to monitor services provided to care homes.

Members of the pharmacy team responsible for making up people's prescriptions used colour-coded baskets to separate each person's medication and to help them manage their workload. Upon receipt, prescriptions, labels, backing sheets and medicine administration record (MAR) charts for the same care home were kept together and processed in a designated colour of basket. And the baskets for each home were kept together throughout the process from receipt of the prescription to dispatch to the home. Team members referred to prescriptions when labelling and picking products. And assembled prescriptions were not dispatched from the pharmacy until they were final and accuracy checked by the responsible pharmacist (RP). The pharmacy team contacted the prescriber or the care home to check interactions between medicines prescribed together. Any interventions were recorded on the patient medication record (PMR). The accuracy checking technician (ACT) accuracy checked prescriptions which she was qualified to check and in line with the company procedure. These were usually not prescriptions for high-risk medicines. There were designated workstations where dispensing and checking took place. And documentation for the multi-compartment compliance aids included a photograph of that patient to confirm identity and help to avoid medicines being given to the wrong

person.

The pharmacy had SOPs for most of the services it provided and these were reviewed. New members of the team completed an induction process. Members of pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. They were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The most recent SOPs related to vaccination services. The pharmacy manager described the delivery procedure for items requiring refrigeration. People using the pharmacy could comment and leave feedback though the complaints procedure, online or by phone. The care homes sent feedback via emails.

The pharmacy displayed a notice that told people who the RP was and it kept a record to show which pharmacist was the RP and when. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy had a controlled drug (CD) register and its team made sure the CD register was kept up to date. The stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded quantity in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. It recorded the private prescriptions it supplied electronically. Records generally were in order. The pharmacy kept a record of deliveries by retaining a duplicate copy of delivery notes for deliveries it made. The pharmacy supplied some medicines via PGD and patient records were maintained for consent, the medicine supplied and when and batch number. And the pharmacy informed the doctor's surgery if people wished.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice on the website that told people how their personal information was gathered, used and shared by the pharmacy and its team. The team tried to make sure people's personal information could not be seen by other people and was disposed of securely. They had trained in general data protection regulation. Each team member had their own password to use the pharmacy's computer and used their own NHS smartcards.

The pharmacy had a safeguarding SOP. And the pharmacy manager had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The pharmacy manager was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work effectively together to deliver services safely and manage the workload. The pharmacy supports them in completing training appropriate to their roles. Team members provide feedback about the pharmacy and how they could improves its services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist who covered three days a week and a pharmacist who worked two days per week. There was extra pharmacist cover when the pharmacy was busy. There was a full-time accuracy checking technician and two full-time dispensing assistants one of whom was the pharmacy manager. And a part-time dispensing assistant. The pharmacy team members had completed appropriate accredited training if needed, the pharmacy also used locum dispensing assistants to manage the workload. Both full-time delivery drivers had trained in the delivery SOPs and policies and were Disclosure and Barring Service (DBS) checked. The pharmacy had a documented business continuity plan to deal with an emergency situation and minimise business disruption.

Members of the pharmacy team had records of training relevant to their roles. They were allocated protected learning time to complete training such as reading through the SOPs. The pharmacy manager described team training regarding switching to a different COVID-19 vaccine. The pharmacy team worked well together so prescriptions were processed safely. They had an annual appraisal to monitor their performance and identify development points. Everyone could share ideas and discuss pharmacy systems such as near misses during their regular team huddles. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, bright and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a large bright dispensary and a counter although it was not open to the public. It was spacious and there were several separate workstations, so each team member had their own workstation.

The pharmacy’s fixtures were in good order. The pharmacy had a consultation room to provide private services such as aesthetics. There was also a large room where the COVID-19 vaccination service was located. There were defined areas screened off where the COVID-19 vaccinations were administered. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. The premises were secured from unauthorised access.

The pharmacy’s website offered General Sales List (GSL) and Pharmacy (P) medicines for sale. This service was provided by a third-party pharmacy registered with the GPhC. The pharmacy did advertise details of this third-party provider on its website although not prominently. The pharmacy’s website displayed some information about services which it provided such as travel vaccinations. People could register on the website and enquire about services. The pharmacist or pharmacy manager contacted these people and responded by email. The pharmacy manager was signposted to GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's working practices are safe and effective. It keeps detailed audit trails to identify who completed actions at each stage and show that its professional services are well managed. The pharmacy obtains its medicines from reputable sources and they are stored securely at the right temperature to make sure they are safe to supply. Team members know what to do in response to alerts and product recalls and they keep records of any medicines or devices returned to the suppliers.

Inspector's evidence

The pharmacy's entrance was on the ground floor and level which made it easier for people who found it difficult to climb stairs, such as someone who used a wheelchair, to enter the building and the pharmacy team tried to make sure these people could use the pharmacy services. The pharmacy had a notices, signage and information on the website which told people when it was open, and where to go for the COVID-19 vaccination clinic. Other notices were displayed to tell people about some of the other services the pharmacy offered. The pharmacy had seating for people to use if they were waiting to be vaccinated. Members of the pharmacy team could speak Farsi, Hindi and Gujarati to help people whose first language was not English. They signposted people to other services via Instagram and Facebook.

People could order their prescriptions through the pharmacy. The pharmacy provided a delivery service to people who could not attend its premises in person up until 8 pm. If this did not suit the person, the pharmacy returned the prescription to the NHS spine so it could be downloaded and dispensed elsewhere. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. For the care homes, deliveries were scheduled in advance and delivered in accordance with the service level agreement (SLA). Cold chain items were delivered within a time frame to ensure the temperature in transit was appropriate. Both delivery people had different routes and each had their own file to retain delivery information.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. Care home staff mostly re-ordered the prescriptions for their residents. And they checked them for changes in medication. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs on the documentation for that patient and patient information leaflets (PILs). So, people had the information they needed to make sure the medicines were administered and taken safely. Members of the pharmacy team knew which of them prepared a prescription and they marked some prescriptions to highlight when a pharmacist needed to provide counselling about the medication they were supplying or if other items needed to be added. The pharmacy team had stickers and information cards to highlight high-risk medicines which were mostly supplied in original packaging and not in the compliance aid. The pharmacist visited the homes to complete an annual audit and monitor patient safety, handling and storage of medicines. The pharmacist provided staff training at the care homes. The pharmacy team members were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled

on its contraindications. The pharmacy had the valproate educational materials it needed. The pharmacy manager said there were no people of child-bearing potential who were supplied a valproate at the time of the inspection.

The pharmacy provided the COVID-19 vaccination service in a clinic room beside the dispensary. It was sectioned off into vaccination pods by means of screens. People could book via the national booking system or walk-in for a vaccination. The people being vaccinated were people aged five years and over. The pharmacist provided the consultation and gained patient consent, clinical assessment and counselling after the vaccination. Records were maintained on Outcomes4Health. A separate team delivered the vaccination service so pharmacy services were unaffected and the superintendent pharmacist (SI) had created a business continuity plan. The SI had updated the professional indemnity insurance to cover the service and supervised learning and training by the vaccination team. There was a cleaning rota and bins for sharps and clinical waste. The vaccination equipment was located in the vaccination room along with a defibrillator. The flu vaccination service was not operational due to lack of flu vaccines stock at the time of the visit. The pharmacy could provide an aesthetics service or refer people to an aesthetics service but currently did not provide this service.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. And the dispensary was tidy. The pharmacy team checked the expiry dates of medicines regularly. And expired medicines found on the shelves were removed. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it mostly stored its CDs, which were not exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock in one of its pharmaceutical waste bins which were collected twice a month by a contractor. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacy manager described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had clean glass measures for use with liquids. The pharmacy team could access up-to-date reference sources online. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of the refrigerator. The pharmacy had a cool box with an integral thermometer and cold packs to transport items requiring refrigeration during delivery. The adrenaline injection kits for treating anaphylaxis were in date and they included different sized needles for injecting different sized people. A defibrillator was kept in the same cupboard. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members used their own NHS smartcards.

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.