General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mamedica Dispensary Limited, Unit 3, West Point, 11 Durham Road, Laindon, Basildon, Essex, SS15 6PH

Pharmacy reference: 9011846

Type of pharmacy: Internet / distance selling

Date of inspection: 08/11/2024

Pharmacy context

This is a distance-selling pharmacy (www.mamedicadispensary.com) and mainly supplies specific controlled drugs. The pharmacy dispenses private prescriptions only. People using the pharmacy are based in the UK. The pharmacy is closed to the public and situated in a business park and medicines are delivered to people via courier.

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	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 has systems in place to identify and manage the risks associated with the services it provides. It protects people's personal information and people are able to provide feedback about the pharmacy's services. The pharmacy keeps the records it needs to by law so it can show that medicines are supplied appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available, and these were up to date and signed by the team to confirm they had read and understood them. The pharmacy provided its services at a distance. Risk assessments had been carried out when the pharmacy had originally opened.

The risk assessments looked at various aspects of the service model including system integration, the type of medicines dispensed by the pharmacy and communication with service users and healthcare professionals. For example, there was a risk that outsourced providers were not qualified, approved or contracted to carry out the required work such as website design or back up of data and this was mitigated by ensuring that the contractors they use in the pharmacy were approved and pre-qualified and were deemed suitable to carry out the tasks required of them with an agreement in place which details the responsibilities of each party in terms of what is outsourced and the key contacts. The risk assessments and standards of the pharmacy practice were reviewed by an external pharmacy consultant every three months. The pharmacy's business involved the supply of unlicenced medicinal cannabis products to people living in the UK against private prescriptions issued by UK-based prescribers. The pharmacy mainly dispensed cannabis in the form of flowers, vape and oils. The pharmacy largely dispensed prescriptions received from its partner clinic which was CQC registered, and also dispensed some prescriptions issued by other clinics. The SI carried out checks on all clinicians that worked in the clinic to ensure they were on the specialist register. Agreements were in place for some prescribers who were not on the specialist register but were working under the supervision of another prescriber. The pharmacy did not supply medicines to children. Prescriptions received were generally for the treatment of chronic pain, epilepsy and other neurological conditions. Consultants issued written prescriptions and uploaded them onto a shared platform that the pharmacists had access to. The pharmacists then carried out clinical and legal checks against the electronic copy. The prescription was not dispensed until the original had been received via tracked post.

The pharmacy recorded dispensing mistakes which were identified before the medicine was supplied to a person (near misses). And those where a dispensing mistake happened, and the medicine had been supplied to a person (dispensing errors). Near miss records were reviewed weekly and any learning points were discussed with the team. Dispensing errors were reported on an incident log and were reviewed by the SI.

The correct RP notice was displayed. RP records and CD registers were kept electronically. The CD registers examined complied with requirements. A balance check could not be carried out during the inspection as the medicines were being dispensed and all entries would be made at the end of the day. The pharmacy recorded the CDs returned from patients in a separate CD register and these were destroyed with a witness. Records for unlicensed medicines dispensed were kept. Private prescription records were made on the computer system. The pharmacy had professional indemnity insurance cover

for the activities it undertook.

There was a contact number and an email address for the pharmacy on its website as well as a form through which people could contact the pharmacy. All team members completed a training module in complaints management. The pharmacy had a complaints log and reviewed this regularly for areas of improvement. Following previous complaints about delays in deliveries, the SI had initiated bimonthly meetings with the delivery service provider to monitor the service and discuss improvements.

All team members completed General Data Protection Regulation and Information Governance training. All visitors were required to sign a confidentiality agreement on entering the premises and only certain members of the team were authorised to open the door to visitors. Different team members had different levels of access to people's information, depending on the requirement. Confidential waste was placed in a separated bin and collected by a specialist contractor.

All team members completed safeguarding training levels one and two. And team members said they would refer safeguarding concerns to the safeguarding lead at the clinic.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its current workload. Team members complete relevant ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy had a customer service team, an admin team, and a pharmacy dispensary team. The dispensary lead, who was also a dispenser, managed the rota and ensured the team were up to date with their workload. At the time of the inspection, there was the responsible pharmacist and the pharmacy manager who was also a pharmacist. The pharmacy dispensary team also comprised of three pharmacy technicians who worked as accuracy checkers, four trained dispensers and two trainee dispensers. Team members normally covered each other's absences. The pharmacy also had a pool of locum pharmacists that it could use and would train them in the specialist service when starting. The customer service team were trained to carry out admin roles and the admin team were trained in customer service, whilst the dispensary team were trained in all aspects of the dispensing process so that they could cover absences.

On starting, all team members completed a range of electronic mandatory training modules, including office safety, whistleblowing, and manual handling. Team members received notifications when new training modules were introduced, or existing modules were updated. The team were up to date with their training. Changes in the service and updates were generally communicated to the team via email from the human resources department. Team members were allocated time to complete training whilst at work.

Pharmacy team meetings were held once a week to discuss rotas, staffing, line management and other dispensary tasks. Pharmacy management meetings were also held weekly to discuss stock management, training, standards and key performance indicators (KPIs). Minutes were available for both meetings. The pharmacy held a virtual daily huddle with the clinic to discuss workload, prescriptions, things that may impact workflow, complaints, and issues, and these were also documented. The dispensary lead had visited the clinic to observe how they worked. The managers, pharmacist and other team members were able to contact the SI and described how it was an open working environment where they felt comfortable to raise concerns or provide feedback and suggestions. The team also had an electronic communication platform to share comments and raise issues.

Staff performance was managed by the talent acquisition manager and their line manger. Team members had a 6-monthly probation review and quarterly reviews for the first year followed by biannual reviews. Team members were provided with ongoing feedback, and this was also discussed at team meetings. Team members were provided with opportunities to develop their skills and complete further training, for example, the dispensary lead was enrolling onto a leadership and management pathway. Team members were set individual KPIs of dispensing a set number of prescriptions each day, which were reviewed weekly. Where KPIs were not being met, this was discussed with the team member to identify any issues or support they required.

The SI was responsible for overseeing the pharmacy and the partner clinic. The pharmacy had been

given assurance that the clinic carried out checks on its prescribers during their onboarding process and also reviewed the prescribers yearly. It flagged any concerns or issues about the prescribers with the pharmacy, for example, a prescriber had not renewed their registration and the pharmacy was notified of this. Patients were generally reviewed by the specialist prescriber for the first year of treatment, after which prescribers who were not on the specialist register continued treatment under a shared care agreement. Pharmacists carried out checks on prescribers form external clinics to ensure they were on the specialist register or that a shared care agreement was available.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services effectively. The pharmacy’s website gives people information about the pharmacy and its services, so that people know how to order their medicines.

Inspector's evidence

The pharmacy premises were clean and organised. There was sufficient work and storage space. Workbenches were kept clutter free. Cleaning was done daily and logged by team members. There were adequate hygiene and handwashing facilities for staff. The pharmacy was closed and could not be accessed by the public. Contact with people was generally via telephone or email. Electronic communication platforms with the clinic were available to the team. The pharmacy was secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

The website displayed the name of the superintendent pharmacist and the pharmacy's registration details. It also provided information on how to order medicines, with links to the pharmacy’s partner clinic.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. People can access the pharmacy's services easily. It stores its medicines properly. And it responds appropriately to product recalls.

Inspector's evidence

The pharmacy's services were accessed at a distance. The pharmacy's website gave details of the SI, his registration number and the pharmacy's contact details. It also provided information about the conditions the medicines treated and provided links to the pharmacy's partner clinic. People could communicate with the pharmacy via telephone, email or by completing a 'contact us' form on the website.

The pharmacy shared a secure digital platform with its partner clinic, where prescribers uploaded the prescriptions before sending them to the pharmacy. The pharmacist carried out a clinical and legal check on the uploaded prescription. Pharmacists had access to the clinical notes and shared care agreements from the clinic, which they used to clinically check the prescription. For prescriptions from external clinics, the pharmacist checked that the prescriber was on the specialist register, and if they weren't they checked that there was a shared care agreement in place. The system alerted the pharmacist if the same medicine was repeated in the last seven days and specific notifications would appear on individual patient medication records to highlight requirements and counselling notes. This meant there was a risk that some frequently requested prescriptions may go unnoticed if the intervals between requests were more than seven days. Clinical interventions and discussions with service users were documented on an electronic record. A copy of all the prescribers' signatures was kept electronically in the pharmacy. The original prescription was posted to the pharmacy via a tracked courier and received by the admin team. The pharmacy team checked the prescriptions received against the system and contacted the prescriber if a prescription was not received. They checked for payment and sorted the prescriptions based on payment status and stock availability. Prescriptions were only dispensed once payment was received. During the dispensing process, team members were seen to be carrying out individual tasks. One dispenser was assigned to picking the medicine, one dispenser was responsible for labelling, dispensing was done by a third dispenser and the final check was carried out by an accuracy checking pharmacy technician. Coloured baskets were used to separate prescriptions.

People who were new to the service were provided with a generic information leaflet which had information about the pharmacy's service. Leaflets were also sent with some medicines containing a QR code, which directed users to an electronic aftercare information booklet. This had information about the specialist medicine, side effects, storage, travel requirements and disposal. The pharmacy relied on advice and counselling being provided to people by the consultants and pharmacists who worked at the clinic. The pharmacists had access to the patient notes and could check if any advice given by the clinic was documented. However, the pharmacists did not routinely check the advice given by the clinic, so they were not able to provide assurance that patients were always given enough information to help them use their medicines safely. People were not counselled about how to spot if the medicines were not suitable to use. However, the pharmacy had been contacted previously by people if they had felt that there was an issue with their medicine. Medicines with issues were returned to the pharmacy and quarantined. These were then returned to the supplier for investigation. The team members were

aware of the tasks that could and could not be carried out in the absence of the RP, although they did not have access to any medicines if the RP was not present.

The pharmacy used a tracked courier service to deliver medicines. Service users received an email to inform them that their medicines were dispatched. Medicines were only delivered to the person and a signature was obtained by the courier service. Medicines were packed were packed in boxes, which were taped with tamper evident seals. In the event that there was no one there to receive the delivery it was returned to the depot. Delivery was attempted on three occasions before the item was returned. Medicines returned to the pharmacy were destroyed. The team accounted for closures of courier companies and bank holidays by planning and communicating to service users the timeframes for ordering medicines. These were communicated a month in advance. People had the option to arrange delivery on a particular day if needed and they could request a copy of their prescription from the pharmacy, which helped people in certain situations like travelling.
Medicines were obtained from five wholesalers. The SI had carried out checks to ensure that the wholesalers had the correct certificates and licenses for controlled drugs, wholesaling, GDP and specials. The certificates and licences were uploaded onto the computer system for each wholesaler. The pharmacy received product recalls from the suppliers via email and actions taken were logged in the CD register and a separate quarantine register. Suppliers provided patient information leaflets with some of the medicines. These included printed leaflets inside the medicine box and QR codes that could be scanned to provide electronic leaflets. The leaflets covered instructions for use, ingredients, warnings, contraindications, adverse reactions, and risks associated with the medicine. Issues with medicines were reported directly to the dispensary and were returned to the manufacturer for investigation.

The pharmacy had a date checking matrix and expiry dates were checked weekly. The pharmacy managers said they did not supply medicines that were due to expire in the next 30 days. The manager said they shared stock expiry dates with the clinic to make them aware of what was available, but he said this did not affect the clinical appropriateness of their prescribing. The pharmacy did not dispense any fridge lines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

Reference sources were available including access to the internet and the team had access to consultants for clinical queries. Computer systems were password protected. Confidential waste was separated and collected by a specialist contractor. As the pharmacy was closed to the public this helped to protect people's confidentiality. Team members had individual logins. Some of the team used laptops, which remained on the premises. All laptops were checked for viruses before use and could only be used by the individual it was assigned to.

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.