General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Meds 2 U, 6 Carlton Business Centre, Carlton, Nottingham, Nottinghamshire, NG4 3AA

Pharmacy reference: 9011898

Type of pharmacy: Internet / distance selling

Date of inspection: 11/01/2023

Pharmacy context

This is a distance selling pharmacy which offers services to people through its website, meds2u.uk. The pharmacy's main service is dispensing NHS prescriptions to people residing in care homes. Members of the public can also nominate the pharmacy to receive and dispense their NHS prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. The pharmacy premises are not accessible to members of the public due to its NHS distance selling model. This means the pharmacy supplies all medicines through its delivery service.

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 about its services. And it uses this feedback to inform change. It monitors these changes to ensure they are working effectively.
2. Staff	Standards met	2.1	Good practice	The pharmacy continuously reviews its staffing levels and skill mix. It plans its workload well to ensure its team members complete tasks safely and efficiently.
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 identifies and manages risks associated with providing its services appropriately. It generally keeps the records it needs to by law up to date. And it keeps people's private information secure. The pharmacy proactively seeks feedback from people using its services. And it acts on this feedback to help inform the safe and effective delivery of its services. Pharmacy team members have the knowledge and ability to recognise and raise concerns to help safeguard vulnerable people. They openly and honestly by discuss mistakes made during the dispensing process. And they act to reduce risk following these discussions.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to support its team members in working safely and effectively. The SOPs were next due for review in October 2023. The team had identified an earlier review date for a SOP associated with the delivery of medicines following a recent trial of barcode technology to support the delivery process. Most team members had signed the SOPs to confirm they had read and understood them. But no SOP learning record was seen for the pharmacy's delivery driver. Both pharmacists on duty confirmed the driver had completed learning associated with the SOPs. Pharmacy team members demonstrated a sound understanding of their roles. And they were observed completing dispensing tasks with care.

Pharmacists provided feedback to team members following mistakes found and corrected during the dispensing process, known as near misses. The team consistently recorded details of the near misses at the time the mistake occurred. And pharmacy team members engaged in monthly patient safety reviews designed to reduce risk. Briefing notes associated with these reviews contained details of the actions taken to improve safety when dispensing medicines. For example, the team had separated amitriptyline and amlodipine tablets on the dispensary shelves to help reduce the risk of a picking error involving these medicines. The superintendent pharmacist (SI) reported that the pharmacy had not been informed of any mistakes found after a medicine had been supplied to a person, known as dispensing incidents. There was a clear process for reporting these types of mistakes. This included sharing learning following incidents through the NHS England's 'Learn from patient safety events' (LFPSE) portal.

The pharmacy had a complaints procedure, and this was advertised on its website. It regularly sought feedback from the care homes it dispensed medicines to. This was done through regular meetings with care home teams and through formal feedback forms. The pharmacy recorded the actions taken in response to feedback to help ensure they worked effectively. For example, the SI had responded to feedback relating to out-of-hours accessibility by providing emergency contact information should a care home require support outside of the pharmacy's operating hours. And the team provided examples of how this arrangement had worked effectively over the Christmas bank holiday period. Another example of feedback had led the pharmacy to change the way it delivered medicines to the care homes. It now clearly identified controlled drugs (CDs) and cold chain medicines to support the homes in managing these higher-risk medicines.

Most team members had completed training associated with protecting vulnerable adults and children.

And the pharmacy had SOPs and contact information for safeguarding agencies available to support its team in reporting these types of concerns. A discussion explored the types of concerns the team may identify in a distance selling pharmacy. The pharmacy held personal identifiable information within the premises. And it suitably protected this information from unauthorised access. A pharmacy team member was observed acting with care to verify a caller's identity before discussing confidential information with them. Pharmacy team members disposed of confidential waste securely by shredding it.

The pharmacy had up-to-date indemnity insurance arrangements. The responsible pharmacist (RP) notice displayed the correct details of the RP on duty. The pharmacy had created its own RP register. The register was kept as sheets of A4 paper with rows of pre-printed days of the month. It contained columns for RPs to add their name, registration number, sign-in time, and sign-out time. But there was no section for recording RP absence. And there was a reliance on using dated and timed footnotes on days when there was a change of RP part-way through the working day. The SI acknowledged the need to keep a compliant register and outlined plans for moving to a new style of register following these issues being brought to their attention. The pharmacy generally kept its CD register in accordance with legal requirements. But it did not routinely record the address of the wholesaler when entering the receipt of a CD into the register. Regular full balance checks of physical stock against the register took place. A physical balance check conducted during the inspection complied with the balance recorded in the register. The pharmacy had a patient returned CD destruction register. And this was kept up to date by the pharmacy team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small, dedicated team of people who work together well. It reviews it staffing levels and the skill mix of its team members continuously. And it effectively plans its workload to ensure its team members do not feel pressurised. Pharmacy team members have the confidence to provide feedback and raise concerns at work. And they communicate well with each other and share learning through regular conversations.

Inspector's evidence

The pharmacy team consisted of the SI, another pharmacist, a pharmacy technician, a pre-registration pharmacy technician, and a delivery driver. It had suitable contingency arrangements to manage periods of absence. Staffing levels and skill mix was reviewed by the pharmacists continuously with the three team members employed in line with the growing business. The team's workload was regularly reviewed to ensure it could be managed safely. And team members could complete workload without feeling pressurised. The team had recently begun to use barcode technology to support the medicine delivery service. And pharmacists explained how this saved time and supported the team in answering queries associated with the service. The pre-registration pharmacy technician and delivery driver were enrolled on accredited learning courses relevant to their roles. They received time and support at work to help them complete this training. Team members engaged in ongoing learning. For example, the team had arranged for bespoke learning associated with the use of electronic medicine administration records (MARs) ahead of starting a new dispensing service to a care home. The pharmacy kept training records associated with this learning. The pharmacy did not have specific targets in place. The current focus was on growing the business and on providing safe and effective dispensing services.

Pharmacy team members did not benefit from a structured appraisal process. They confirmed they received regular feedback and support from both pharmacists. The pharmacy had a whistleblowing policy and its team members understood how they could raise and escalate a concern at work. They were confident in putting forward their ideas. And they felt their ideas were taken onboard when pharmacists made decisions about service delivery and workload management. Pharmacy team members communicated well with each other to manage workload. And they engaged in regular conversations at work to share learning following mistakes or feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, tidy, and secure against unauthorised access.

Inspector's evidence

The pharmacy had moved from another unit within the business centre in July 2022. Its website included the name, address, and contact information for the pharmacy. But it displayed the registration number of the previous premises. This meant that people may not be able to find the premises as registered on the GPhC website using the registration number displayed. The SI contacted the website provider during the inspection to update this information.

The pharmacy was on the ground floor of the business centre. It was secure from unauthorised access. The floor area was clear of hazards, and the premises were clean and tidy. Team members used separate workspaces for safe and effective dispensing which were well organised and uncluttered. The SI regularly assessed the appropriateness of the premises based on any changes in workload to ensure it remained fit for purpose. Lighting throughout the pharmacy was bright and ventilation was appropriate. The team monitored the room temperature in the pharmacy. Team members had access to communal toilet and kitchen facilities which contained appropriate hot and cold water for hand washing. A sink within the premises provided cold water only.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. The pharmacy team members work well to manage dispensing services efficiently. And they provide relevant information to people to help them take their medicines safely.

Inspector's evidence

People accessed the pharmacy's services through either the website, by email or by telephone. The pharmacy's website provided clear information about the services provided. And it provided a range of links to health and wellbeing websites. Pharmacy team members understood how to signpost people to other pharmacies or healthcare providers if they were unable to provide a service. The team provided examples of working effectively with other healthcare professionals to support positive outcomes for people. For example, they engaged regularly with Primary Care Network (PCN) pharmacists when managing changes to people's medicine regimens.

Pharmacy team members communicated with surgeries and care homes via secure NHS email. This meant they had an audit trail to support them in answering queries and communicating outcomes to people. The team monitored the receipt of prescriptions and ensured queries were resolved ahead of scheduled supply dates. The pharmacy supplied medicines to care homes through an original pack dispensing model. The team used a board in the dispensary to plan workload associated with the service. There was evidence of effective planning when beginning the supply of medicines to a new care home. This included reviewing schedules associated with the supply of medicines to other care homes to ensure the team could cope with the extra work. It provided MARs for both regular and acute medicines. The MARs seen included identification photographs and allergy information to support care home teams in administering medicines. They also identified higher-risk medicines. For example, MARs provided alongside insulin regimens contained additional sections to support effective record keeping.

The team engaged in regular audits associated with the supply of higher-risk medicines. It documented the outcomes of these audits and the actions taken in response to them. A discussion took place about the safe supply of valproate medicines. This included the placement of labels on valproate packaging and the effective use of branded packaging to support the pharmacy team in supplying the patient card to people within the at-risk group. An audit associated with the supply of valproate to a person in the at-risk group confirmed the team had followed the requirements of the valproate Pregnancy Prevention Programme (PPP). The pharmacy provided INR monitoring charts when dispensing warfarin to people residing in care homes. But it did not request a copy of the completed monitoring chart to assure itself that people were regularly monitored and to assist it in its own record keeping.

Pharmacy team members generally took ownership of their work by signing the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. But a full dispensing audit trail was not routinely provided when supplying medicines in multi-compartment compliance packs. A team member detailed recent changes to the compliance pack service to help plan workload and these changes were monitored to ensure they were working effectively. The team used the patient

medication record (PMR) system to support the dispensing of compliance packs. And team members recorded changes to medicine regimens on individual paper-based records. Some but not all of these changes were also recorded on the PMR. And there was no clear indication that a pharmacist had acknowledged the change as part of their clinical checking process. A sample of assembled packs found clear descriptions of medicines on the backing sheets attached to the compliance packs. But the backing sheets did not include adverse warnings as required. The team resolved this concern during the inspection by switching the style of backing sheet. It supplied patient information leaflets at the beginning of each four-week dispensing cycle.

The team used baskets throughout the dispensing process. This helped to organise workload and kept medicines with the correct prescription. It clearly recorded owed medicines, and informed people and care home teams of any medicines that could not be immediately supplied. It kept original prescriptions and used these to support the dispensing process when supplying owed medicines. The pharmacy maintained an audit trail of the medicines it delivered. The team had recently started using barcode technology to support part of the delivery process. It had procedures to support the delivery of medicines outside of the local area. The RP provided an example of one of the couriers the pharmacy would use in the event it needed to send a cold-chain medicine via this supply route. The courier specialised in the transit of temperature-controlled items. All deliveries to date had been made through the local delivery service.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage in the dispensary was orderly with most medicines stored in their original packaging. It stored a small number of medicines in labelled amber bottles. The labels on the bottles did not always contain the full details of the medicine held inside them such as the batch number and expiry date. The team acted to transfer these bottles and a few loose capsules found on a shelf above the compliance pack dispensing area to the medical waste bags provided. The pharmacy stored medicines subject to safe custody arrangements appropriately in a secure cabinet. Medicines inside the cabinet were stored in an orderly manner. It stored medicines subject to cold chain requirements safely in a medical refrigerator. But its fridge temperature record contained gaps. Temperatures recorded either side of these gaps had remained within the temperature range of two and eight degrees Celsius as required. The team followed a date checking rota. This helped to manage stock and identify short-dated medicines. Team members generally annotated liquid medicines with details of the dates they had been opened. This prompted checks during the dispensing process to ensure the medicine remained safe to supply. No out-of-date medicines were found during random checks of dispensary stock. The pharmacy had medical waste bags available to support the team in managing pharmaceutical waste. It kept evidence of waste collections and additional collections it organised to ensure medicine waste did not build-up. It received details of drug alerts and recalls through the MHRA’s central alerting system. And it kept a record of these alerts and the action it had taken in response to them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment for the delivery of its services. And its equipment protects people's private information from unauthorised access.

Inspector's evidence

Pharmacy team members had online access to up-to-date reference sources including the British National Formulary (BNF) and BNF for children. They were able to make use of local medicines information pharmacists at the local hospital for any other queries. They also kept themselves up to date with the most recent information provided by the Care Quality Commission (CQC). This helped them to answer any queries from care homes. The team used passwords and personal NHS smartcards to access the computers. And computer screens were positioned suitably to prevent information from being read by unauthorised personnel. The pharmacy had crown marked conical flasks suitable for the measuring of liquids. And these were available in a variety of different volumes. It had suitable equipment for counting tablets and capsules and it generally kept these clean. Team members used separate equipment for counting cytotoxic medicines to prevent any cross contamination.

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.