General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: MedPro Pharmacy, Unit 1, Oak Tree Business Park, Philip Ford Way, Silfield, Wymondham, Norfolk, NR18 9AQ

Pharmacy reference: 9011939

Type of pharmacy: Internet / distance selling

Date of inspection: 22/11/2024

Pharmacy context

This pharmacy is located in the town of Wymondham in Norfolk. Its main activities are dispensing NHS prescriptions, administering seasonal flu vaccinations and COVID vaccinations and providing the Pharmacy First service under patient group directions (PGDs). The pharmacy delivers all the medicines it dispenses to people's homes. The owner also administers a small number of aesthetics injections to people at the pharmacy.

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 generally manages the risks associated with its services and it generally keeps the records its needs to by law. It also keeps adequate records about the aesthetics services it provides. The pharmacy has appropriate insurance arrangements in place. Team members know how to protect vulnerable people. And the pharmacy handles people's private information safely.

Inspector's evidence

The correct responsible pharmacist (RP) notice was displayed in a prominent position in the pharmacy. There was a range of standard operating procedures (SOPs) available electronically. The SOPs had been read by all team members. Some SOPs had been reviewed earlier in the year, but some had not been reviewed for several years. The RP said he would inform the superintendent pharmacist (SI) of this. A team member was able to explain her roles and responsibilities within the pharmacy. And she also knew what activities she could and could not do in the absence of an RP.

The main business of the pharmacy was dispensing and delivering NHS prescriptions to people and administering flu and COVID vaccinations under PGDs. The pharmacy's website advertised that the pharmacy provided an online prescribing service for some conditions such as asthma and pain relief. Before obtaining a prescription from the pharmacy for this online service, the person needed to complete an online questionnaire related to the condition they were requesting treatment for. However, technical issues meant that this service wasn't working as indicated on the website. This could cause confusion and potential delays for people seeking treatment. The RP said he was not prescribing any medicines for people as he did not feel confident to do so and was instead contacting people by phone and informing them of this before offering a refund and advising them to contact their GP.

The pharmacy also advertised that they sold a small number of General Sales List (GSL) and pharmacy only (P) medicines via the website. For P medicines a questionnaire needed to be completed and sent to the pharmacy and the person needed to upload a picture of their ID. Most of the items on the website were listed as being out of stock. The RP said that the number of orders of P medicines was also very low with only a couple of orders received per week. The RP said that most of these orders were rejected and refunded due to the pharmacy not having stock of the medicine. He also said he would call all people who requested a P medicine from the website before issuing and would also call anyone who's order had not been fulfilled. Only one example was seen of a supply of a medicine from the website with the RP recording details of the discussion he had with the person.

Shortly after the inspection the SI was contacted to discuss the website and the SI stated she would look into removing the questionnaires and information about online prescribing and sales of medicines so people would not be misled into believing they could purchase a medicine or get a prescription from the pharmacy. The SI also sent evidence of some risk assessments that had been completed for the online prescribing and online sales of medicines as well as some policies and procedures relating to the online prescribing service.

The pharmacy offered aesthetics services including botulinum toxin injections and fillers. These services were completed by the pharmacy's owner who was also a pharmacist independent prescriber (PIP). The

SI sated that the volume of service for aesthetics was very low with only one booking every four to eight weeks. To access the service people needed to book an initial consultation online. All subsequent consultations took place face to face at the pharmacy. If the person was suitable for treatment, the owner would issue a private prescription for the required medicine which was dispensed at a different pharmacy. The medicine would then be sent to MedPro pharmacy, and the person would attend for treatment. The owner said he brought a reversal kit, which contained the appropriate items including hyaluronidase, with him to each appointment in case of any complications when administering the aesthetic treatments. And he had access to an emergency protocol. The owner provided evidence from previous consultations with people to show that appropriate consultation notes were being made. Batch numbers and expiry dates of medicines used were also recorded in case there were any recalls. The owner carried out face mapping for each consultation and took before and after photos, so he could be sure where the injections had been administered if there were any complications. The owner had the appropriate insurance to carry out aesthetics services. And he had completed relevant training and certificates were seen to show this. The owner confirmed that he only provided treatment to people over the age of 18.

Near misses (dispensing mistakes which were spotted before a medicine left the pharmacy) were recorded electronically in a good level of detail. However, near misses were not being recorded regularly with the most recent entry being from 2023. The RP said he did not always have time to record near misses but said that each near miss was discussed with the team member involved. Dispensing errors (mistakes which had reached a person) were recorded electronically in more detail than near misses. The RP said that when an error occurred a report was be completed and submitted to the National Reporting and Learning System (NRLS). The RP said a meeting would also be held to discuss the error. The RP explained that following a previous error two similar-sounding medicines had been separated on the pharmacy shelves to reduce the chance of a similar error occurring again.

Complaints and feedback were usually submitted online with details about how to do this available on the pharmacy's website. The team confirmed that any complaints or feedback about the pharmacy could also be given via a phone call and would be actioned in the same way. Complaints were usually dealt with by the RP but could be escalated to the SI if necessary. Confidential material was shredded on site once it was no longer needed. The RP confirmed that he had completed level three safeguarding training. The RP had not had to deal with a safeguarding issue, but there were details of local safeguarding contacts available in the pharmacy.

The pharmacy had current indemnity insurance. Balance checks were carried out for controlled drugs (CDs), and records seen in the CD register were made in accordance with the law. A random check of a CD showed that the quantity in stock matched the running balance in the register. Records seen about private prescriptions dispensed were not complete with some entries seen missing the details of the prescriber, and some recent entries had not yet been entered in the register. The RP gave assurances that all entries would be made in the register and would include all the required details. RP record was complete with all entries seen having a start and finish time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. And they complete the right training for their roles. Team members do some ongoing training to keep their knowledge and skills up to date. And they feel comfortable about raising any concerns they may have.

Inspector's evidence

The team consisted of the RP and one dispenser. There was also another dispenser and two delivery drivers who were not present during the inspection. The pharmacy had enough team members to manage its workload effectively, and the team was up to date with dispensing. The RP confirmed that all team members had completed or were in the process of completing the appropriate training for their role with an accredited training provider. The RP explained that team members were provided with ongoing training in the pharmacy, usually when a new medicine was available, or a new pharmacy service was being introduced and that they were sent training materials by the SI. Team members had regular reviews with the RP or SI every few weeks to monitor their progress. They had no concerns raising any issues and would usually go to the RP but could go to the SI if necessary. Team members were observed working in a safe and efficient manner during the inspection. The RP confirmed that team members were not set any targets in the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy and provides a safe and appropriate environment for the provision of its services. It has consultation rooms for people to have private conversations with a member of the team. And the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The front facia of the pharmacy was in an adequate state of repair. The pharmacy had chairs for people who wished to wait to access the pharmacy's services. The pharmacy had a consultation room for people who wished to have a conversation in private. There was also another room used for administering aesthetics injections. Both rooms were of an appropriate size and were clean and tidy. The dispensary area was generally clean and tidy and had just enough space for team members to carry out their work. There was a sink for preparing liquid medicines which was clean. The temperature and lighting in the pharmacy were adequate. And there was central heating available to help maintain the room temperature. There was a staff toilet with access to hot and cold running water and handwash. The pharmacy was kept secure from unauthorised access.

The pharmacy's website had details of the pharmacy including the address, contact details and General Pharmaceutical Council (GPhC) registration number. However, it displayed the details for the previous SI, not the current one. This was updated shortly after the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its medicines and services safely. People with different needs can access the pharmacy's services. It gets its medicines from licensed sources. But it does not always store these in an organised way which could increase the risk of errors occurring.

Inspector's evidence

The pharmacy had step-free access via a manual door. People could visit the pharmacy to access services such as vaccinations, but no one could collect NHS prescriptions from the pharmacy. There was enough space for people with wheelchairs and pushchairs to access the waiting area. Reasonable adjustments were made for people with different needs, for example by printing large-print labels for those with sight issues. The dispensary had separate areas for dispensing and checking medicines and baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines seen contained the initials of the dispenser and checker which provided an audit trail of who was involved in the respective processes.

The pharmacy delivered all medicines to people. The pharmacy provided the delivery drivers with a paper copy of people's details which the drivers used to make deliveries. These were returned to the pharmacy and disposed of after usage. The RP said that some deliveries would be left in a nominated safe place if no one was in and only if this was agreed with the person beforehand. This did not apply to CDs. If there was a failed delivery, the medicines were returned to the pharmacy and a note put through the door with information about arranging a re-delivery. The pharmacy used a third-party delivery service for any medicines purchased through their website. There was a range of delivery options available which all used a tracked delivery method.

The pharmacy obtained medicines from licensed wholesalers. CDs requiring safe custody were stored securely. Medicines requiring refrigeration were stored appropriately in two fridges in the pharmacy. Fridge temperatures had not been recorded on several days. However, the records seen for when temperatures were recorded showed the temperature to be in range. And the RP gave assurances that going forward, fridge temperatures would be monitored daily. The maximum and minimum temperature of one of the fridges were found to be outside the required range during the inspection. The thermometer was reset and subsequently showed a temperature within the required range. Temperatures for the other fridge were all found to be in range during the inspection. Expiry date checks were carried out every three months. A random check of medicines on the shelves found no expired medicines. However, some medicines were not stored neatly on the shelves and there was a lack of clear division between medicines of similar strengths on the shelves. This could increase the change of picking errors occurring. The RP said that he and the team would tidy the shelves and separate medicines more clearly.

Safety alerts and recalls were received electronically via an online portal. The RP stated that he was reviewing these alerts when they came in to see if the pharmacy was affected. But he was not always recording the action taken or signing off some alerts as complete. So, this could make it difficult for the pharmacy to find out what action they had taken for an alert. The RP gave assurances that all actioned alerts would be marked as completed and the action taken recorded. Team members were aware of the risks of sodium valproate, and the RP knew what to do if a person in the at-risk category presented

at the pharmacy. And he was aware of the guidance change with regards to supplying sodium valproate in its original pack. Team members knew where to apply a dispensing label to a box of sodium valproate so as not to cover any important safety information. The pharmacy had the appropriate PGDs available for the services they were providing. These were in date but had not been signed. The RP said he would sign the PGDs as a priority.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment to protect people’s privacy.

Inspector's evidence

The pharmacy computers had access to the internet and team members accessed any online resources they needed. Team members were observed using their own NHS smartcards. The pharmacy had cordless phones so conversations could be had in private. Electrical equipment looked to be in working order. The pharmacy had a blood pressure machine in the consultation room. The RP was unsure how old it was but said he would check and get it replaced or recalibrated if necessary. The pharmacy had the appropriate calibrated glass measures for measuring liquid medicines. It also had tablet triangles for counting medicines. This equipment was clean and fit for use.

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.