General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicine Drop, Clinical Care Ltd, Unit 3- 4, The Brian Clough Business Centre, 200-222 Cotton Lane, Derby, Derbyshire, DE24 8GJ

Pharmacy reference: 9012162

Type of pharmacy: Internet / distance selling

Date of inspection: 11/01/2024

Pharmacy context

This is a distance selling pharmacy located in an industrial estate in Derby. People cannot usually visit the pharmacy in person, and it provides its services remotely. It mainly supplies medicines to people that are in care homes but also supplies some medicines to people living in their own home. And the pharmacy offers some limited NHS services such as the Community Pharmacy Consultation Service and Discharge Medicine 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	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 written procedures to help make sure team members provide its services safely and effectively. And it keeps the records it needs to by law. It makes records of mistakes that happen during the dispensing process, and it regularly reviews these so that its team members can learn from them. Members of the pharmacy team effectively keep people's private information safe, and they know how to safeguard people that may be vulnerable.

Inspector's evidence

The pharmacy had Standard Operating Procedures (SOPs) which covered all the services that were being provided. They were last reviewed in October 2023 following the installation of a dispensing robot. Electronic training records were available to show all team members had read the SOPs that were relevant to their role. Members of the team knew their role for the day and what workload needed to be completed. And they were aware of the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. The pharmacy had professional indemnity insurance in place.

The pharmacy had a process to support the team with learning from mistakes that were identified during the final check by the accuracy checker, also known as near misses. The team member completing the accuracy check would ask the team member involved in the dispensing process, to identify the mistake and correct it. The error was then logged on an electronic near miss record by the accuracy checker. A dispenser who worked as an accuracy checker (ACD), explained that this helped to improve the reporting of errors rather than relying on a member of the team to record it whilst they were busy with the assembly of prescriptions. The superintendent pharmacist (SI) reviewed the near misses each month and shared the learnings with the team members so that learning opportunity were not missed. They also explained discussions were held with any team members that were consistently making mistakes so that any training and development opportunities could be identified. Any mistakes identified after medicines had been handed out(dispensing errors) were recorded and filed securely; these were discussed with the team members to help reduce the risk of similar mistakes happening again.

The pharmacy's RP record and private prescription register were completed in line with requirements. Electronic controlled drug (CD) registers had been filled in correctly and running balances were maintained. CD balance checks were carried out infrequently. This could result in any discrepancies not being noticed promptly. Running balances for four CDs were checked and one did not match the physical quantities that were being held in the cabinet. The SI agreed to investigate the discrepancy and was able to correct it. It was agreed that CD balance checks will be completed more frequently to help make sure the running balances match the physical stock being held in the pharmacy. CDs that were returned to the pharmacy were recorded in an electronic patient returns register and the entries were signed when the medicines were destroyed. The pharmacy supplied some unlicensed medicines to people, and it kept a record of these supplies.
The pharmacy had a process for managing complaints and the team were aware of the steps to follow if a complaint needed to be escalated. In the first instance, team members would try to resolve a complaint verbally but would refer to the SI if it required escalation. The pharmacy had a confidentiality

policy which all team members had read. When questioned, members of the team described the ways in which they protected people's private information. For example, they knew not to share people's private information. And they used a shredder to destroy confidential waste. Members of the pharmacy team were aware of the safeguarding procedures that were in place and what to do if they have any concerns to support the wellbeing of anyone vulnerable. Details of the local safeguarding contacts were easily accessible

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. It provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy had a large team that consisted of two regular pharmacists, one of which was the SI, one qualified dispenser who worked as an accuracy checker (ACD), five qualified dispensers, one qualified pharmacy technician and three delivery drivers. There were also several members of the team who were undergoing training to obtain a qualification suitable to their role. This included five apprentices working towards an NVQ2 dispenser qualification, eight trainee dispensers, and two dispensers working towards becoming an ACD.

One of the dispensers worked as a floor manager and they managed the daily operations of the pharmacy. The management team consisted of three directors, one superintendent pharmacist, one regular pharmacist and one ACD. They oversaw the training and team members felt well supported with their learning and development. Members of the team were provided with protected learning time. The directors also provided ongoing mandatory training for team members to complete every one to two years. This included training on safeguarding vulnerable people and health and safety.

Team members were seen managing the workload safely and they communicated well with each other when processing prescriptions. The floor manager worked closely with the directors, and they delegated tasks to members of the team each day. This helped to make sure that the workload was completed in a safe and timely manner.

The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the management team. Regular team meetings were held so that members of the team could ask for support when it was needed to help manage the workload. A team meeting was held every Wednesday and team members were encouraged to discuss positive outcome scenarios and processes that are working well to help motivate members of the team. They also discussed any near misses or dispensing errors along with any process changes. Team members had key performance indicators (KPIs) in place to help manage the workload. When questioned, several members of the team explained that the KPIs were achievable and did not compromise patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are clean and tidy. A consultation room is available so the team can have private conversations with people.

Inspector's evidence

The pharmacy was large, clean, and well-lit which made it suitable to supply medicines in an effective manner. There was enough organised workspace for its team members to assemble medicines safely. The pharmacy had separate labelling, assembly and accuracy checking stations which made it easier to help with the workflow. The pharmacy was cleaned by members of the team at the end of each day.

A clean and tidy separate room was available which was mainly used for the pharmacists to complete clinical checks of the prescriptions that the pharmacy received. But it was also suitable for people to have a private conversation if needed. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy was secured when closed.

The pharmacy had a website, www.medicinedrop.co.uk, which detailed the address and registration details of the pharmacy. It also displayed the registration details of the SI. The pharmacy did not sell any medicines via its website, but people could request to speak to a pharmacist when advice was needed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides the services it offers in a safe manner. The pharmacy gets its medicines and devices from appropriate sources. And pharmacy team members take appropriate action if medicines or devices are not safe for people to use. Members of the team give advice to people when supplying higher-risk medicines to help make sure they are being used safely.

Inspector's evidence

The pharmacy was offering its services at a distance as it was not open for people to visit in person. It had a website which encouraged them to sign up online so that their NHS prescriptions could be sent directly from their doctor to the pharmacy and then delivered to them. The pharmacy mainly supplied medicines to people that resided in care homes. Most of the care homes ordered the prescriptions they needed the pharmacy to dispense, and, in such instances, the care home provided the pharmacy with a copy of the medicines that had been ordered. Where the pharmacy ordered medicines on behalf of the care home, or for people living in their own home, a copy of the request was retained. The pharmacy had a customer service team, and their job was to answer queries about people's medicines and to check that the prescriptions that the pharmacy received matched the medicines that had been requested from the GP. Any discrepancies were queried with the GP by the customer service team, and they would notify the care home of any medicines that had not been prescribed.

The pharmacy received prescriptions electronically and were clinically checked by the pharmacist before being processed for assembly. The pharmacy computer system also carried out some clinical checks based on the patient's medicine history. If there were no changes to the previous month, then a clinical check would automatically be completed. Any medicines changes, including changes to the dosage or form, required a pharmacist to confirm that the prescription was clinically safe. Once the clinical check was complete, the prescription was processed by a dispenser. A dispensing robot was used to help members of the team assemble prescriptions and they had to scan a 2D barcode on the medicine packaging to generate a dispensing label. This helped to make sure that the correct medicine had been dispensed. If all was correct, a label was generated and attached to the medicine box. If there was a mismatch between the dispensed medicine and the prescription, a warning box would appear on the computer to prompt the team member to double check the medicine. The SI and floor manager explained that this had helped reduce the number of near misses considerably. Medicines that required an accuracy check by the ACD or pharmacist were put into a basket and placed in the 'checking area'. The pharmacy computer system also completed some of the accuracy checks if the prescriptions and medicines were all scanned in properly. Any prescriptions that were manually changed by a member of the team, for example a change in dosage instructions from the details on the prescription, required an accuracy check by a pharmacist or ACD. Baskets were used to separate people's prescriptions and different coloured trays were used to help prioritise the workload. Each dispensing label had a 2D barcode printed on it and when scanned it showed who was involved in the dispensing and checking process. This meant that the pharmacy could easily identify which members of the team were involved in the assembly of a prescription if a dispensing mistake was to occur.

The pharmacy supplied some medicines in single medicine compliance packs to people in care homes. Medicines supplied in the packs were de-blistered by a member of the team and then loaded into a dispensing robot which produced the packs. A record of the batch numbers and expiry dates of the

medicines were maintained in the event of a drug recall or safety alert. The packs were labelled and then accuracy checked by the ACD or pharmacist before being supplied to the care homes. Some NHS services were being provided which included the Community Pharmacy Consultation Service (CPCS) and the Discharge Medicine Service (DMS). In both cases the pharmacy kept records of the services provided including any hospital discharge summaries.

The pharmacy delivered medicines to people's homes or directly to the care homes. Medicines were placed into boxes and the name of the patient was clearly stated on the box along with the delivery address. Any prescriptions that required the addition of a CD or fridge line was clearly marked using a sticker. Prescriptions for Schedule 2, 3, and 4 CDs were highlighted to help the pharmacy team members make sure they were not delivered beyond the prescription's legal validity. All medicines were delivered by one of the pharmacy's delivery drivers. They used an electronic system to log the deliveries which maintained a record of the medicines that had been delivered. A signature was required when medicines were delivered to people. This helped to create an audit trail if a query arose following the delivery of a medicine.

The pharmacy had a process in place to provide additional advice to people who were supplied with higher-risk medicines. The pharmacy team marked any prescriptions that required the pharmacist to provide extra information to help make sure the medicine was safe to use. The pharmacist was aware of the additional counselling required by the Pregnancy Prevention Programme with sodium valproate products and the steps to take for people in the at risk-group. This also included providing valproate containing medicines in its original container so that the patient warning card and patient information leaflet were provided with each supply.

The pharmacy used a range of licensed wholesalers and medicines were stored appropriately in the original packs. Access to prescription medicines was restricted. The expiry dates of medicines were checked every Friday by members of the team. But they did not make a record of completed checks so it may make it harder to identify which areas of the pharmacy have been checked and by who. A selection of medicines stored on the shelves were checked, and none were found to be out of date. And liquid medicines had a date of opening written on them. Medicines stored in the robot were scanned using a 2D barcode as part of the filling process which captured information about its expiry date. Team members were alerted to short-dated medicines so that they could be used first or removed from the robot for destruction. The pharmacy had several suitable fridges available, which was within the appropriate temperature range for medicines that required cold storage. A daily record of the fridge temperatures was stored electronically. The pharmacy had a secure CD cabinet available to use. CDs that had been returned to the pharmacy were clearly marked and separated from stock CDs. The pharmacy received alerts regarding defective medicines by email. Its team members checked the pharmacy for any affected stock but did not make a record of the actions taken. This may make it harder for them to respond to any queries following a safety alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. There were several fridges in the dispensary. Members of the team had access to electronic resources such as the British National Formulary (BNF) and Drug tariff. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy had an automated dispensing robot for both original pack dispensing and single medicine compliance packs to help its team members assemble medicines for final checking by an ACD or pharmacist. The robot was serviced regularly and had a maintenance contract in place. Electrical equipment looked to be in good working order and was last tested in November 2023. Access to people's electronic data on the pharmacy's computers were password protected.

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.