General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Netscripts Direct, Unit 15 Byron House, Hall Dene Way, Seaham Grange Industrial Estate, Seaham, Durham, SR7 0PY

**Pharmacy reference:** 9012323

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 28/11/2024

## Pharmacy context

The pharmacy is in an industrial estate in Seaham, County Durham. It has a distance selling NHS contract. Pharmacy team members dispense NHS prescriptions and deliver them to people's homes. They provide medicines to some people in multi-compartment compliance packs. And they provide medicines to people living in care homes and nursing homes. People access services through the pharmacy's website, netscriptsdirect.co.uk.

## 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 suitably identifies and manages risks associated with its services. It generally keeps the records required by law. Team members keep people's confidential information secure. And they know how to identify situations where vulnerable people need help. Pharmacy team members learn and improve from mistakes. The pharmacy has written procedures relevant to its services and team members follow these to help them provide services safely.

### Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) to help its team members manage the risks associated with providing its services. Each SOP included the date of issue and review. All the SOPs had passed their stated review dates by almost a year. This meant that the content of the SOPs may not always fully reflect the way the pharmacy provides its services. The responsible pharmacist (RP), who was also the superintendent pharmacist (SI), explained that team members had been made aware of any changes to procedures that had been introduced, but the SOPs had not yet been updated to incorporate them. The SOPs were held in an organised file so that team members could access them easily. Each SOP clearly defined which roles within the team held responsibility for a procedure. This helped members of the team to work safely within their remit. All team members had read the SOPs and had signed to confirm they had understood them.

The pharmacy team recorded near miss errors, and from the records seen, this was done regularly throughout the month. These errors were mistakes identified before people received their medicines. Separate logs were in use for the care home section of the pharmacy and for the main part of the dispensary to cover all other workload. This meant that any trends identified, and subsequent learning points were more specific to the separate areas. The RP and pharmacy technician took responsibility for recording these errors and the team member who made the error corrected the mistake. This meant they had the opportunity to reflect on what had happened. The SI reviewed these errors monthly to produce learning points for the team. These were shared with the team as part of regular briefings delivered by the pharmacy manager and the pharmacy technician. The pharmacy also had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. The SI provided detail about a dispensing error that occurred earlier in the year, and the changes the pharmacy had made to prevent similar incidents happening. This included an additional pharmacist accuracy check on more complex multi-compartment compliance packs.

The pharmacy had a documented procedure for dealing with complaints. The pharmacy's website clearly laid this out, including the details people would need to provide feedback to the pharmacy. Pharmacy team members advised they usually received feedback from people verbally or via email. And they provided examples of changes made in response to a complaint relating to the delivery of a multi-compartment compliance pack. The pharmacy had current professional indemnity insurance. There was no Responsible Pharmacist notice on display at the start of the inspection, so people could not easily identify who the RP was. A notice was produced and displayed as soon as this was pointed out. Team members knew what activities could and could not take place in the absence of the RP. And they knew what their own responsibilities were based on their role within the team. Pharmacy team members explained how they worked safely with different roles in the team completing the accuracy check of a prescription. The pharmacy technician worked as an accuracy checker (ACT) and the SI explained how

they followed a documented protocol for the dispensed items they checked, to ensure prescriptions had undergone a professional check by a pharmacist.

The pharmacy kept its RP log electronically. A sample of RP records checked were found to be regularly lacking RP sign out times. This meant the pharmacy may not always be able to demonstrate when an RP was in place. The pharmacy also kept its private prescription records electronically and these were generally found to be in order. The pharmacy team completed weekly checks of the running balance in the CD register against the physical stock. Three random balance checks were carried out and found to match the quantities of stock present. The pharmacy kept a register of CDs returned by people, and there were recent records of these returns being destroyed.

The pharmacy had a procedure for keeping people's personal information safe and it kept confidential waste and general waste separate. Team members used a shredder to destroy confidential waste. They completed this activity daily to ensure a backlog did not build up. The pharmacy had a procedure for the safeguarding of vulnerable people. Most of the team had completed formal safeguarding training. The SI gave examples of where they and team members, including delivery drivers, had acted on concerns they had about people that were considered vulnerable.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together and within the scope of their competence. And they have opportunities to complete ongoing training so they can develop their knowledge. Pharmacy team members know how to raise concerns, if needed.

### Inspector's evidence

At the time of the inspection, the RP was the superintendent pharmacist and owner of the pharmacy. They were supported by a team who consisted of a regular, part-time pharmacist, a trainee pharmacy technician, five qualified dispensers and a trainee dispenser. Team members who were not present during the inspection included a full-time regular pharmacist, and a pharmacy technician who worked as an accuracy checker (ACT). The team were observed to be calmly managing the workload throughout the inspection. Team members worked well together. And they communicated effectively to plan and handover key tasks. The SI explained that there was contingency for staff absence in the number of team members employed. The competence and skill mix of the team appeared appropriate for the nature of the business and the services provided.

Four delivery drivers were employed by the pharmacy. They had all received some training during their induction but had not yet started any formal training. Following the inspection the SI confirmed that all the drivers had been enrolled on a recognised training course. Other team members completed various training to support their development. Team members completed training related to the accredited courses on which they were enrolled. During the inspection, team members were observed using protected learning time to complete coursework. And more experienced team members supported them to do this.

The SI carried out annual performance and development reviews with members of the pharmacy team. They explained that these usually take place in an environment away from the pharmacy, so to avoid interruptions and allow open communication. Pharmacy team members felt comfortable sharing ideas to improve the pharmacy’s services. They explained how they would raise professional concerns with the SI. And they were confident that any concerns raised would be listened to and appropriate actions taken to improve the services the pharmacy was providing. The pharmacy team was not set any performance targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it offers. And its website generally contains the information that people using its services may need. And pharmacy team members properly secure the pharmacy to prevent unauthorised access.

### Inspector's evidence

The pharmacy was in a business unit and unauthorised access was controlled via magnetic locking front door with keycard access. The premises consisted of a large open plan main dispensary, as well as several separate areas used for care home dispensing and compliance pack storage. The premises was a good size for the workload being undertaken, with ample bench space throughout. Walkways were kept clear to minimise trip hazards. And there was sufficient storage space for stock, assembled medicines and medical devices. The layout of the dispensary supported the RP's supervision of the pharmacy team completing activities. The lighting and temperature were suitable to work in and to provide healthcare services. The team had access to a well-maintained sink in a kitchen area, with hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic.

The pharmacy's website displayed details pertinent to the pharmacy, as well as those of the owner and SI. But some of these required updating, following the pharmacy's relocation to a newer premises. The pharmacy premises had an overall appearance which was suitably professional. The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks as required. The pharmacy had a room that was suitably constructed to function as a private consultation room.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy sources its medicines from recognised suppliers. And it stores and manages them appropriately. Pharmacy team members complete regular checks to ensure medicines are suitable for supply. And they respond appropriately when they receive alerts about the safety of medicines. Team members appropriately manage the safe and effective delivery of services. And they take opportunities to provide people with advice on higher-risk medications.

### Inspector's evidence

People did not visit the pharmacy to access services. They communicated with the pharmacy by telephone and email. The pharmacy had a website, https://netscriptsdirect.co.uk, where it provided its contact details and information about its services. This included details of what support the pharmacy could offer to people who required it, such as easy open medication bottles or large font medication labels.

The pharmacy delivered all the medicines it dispensed. The assembled bags of medicines were stored in a designated area when they were ready for the driver to deliver them. The driver scanned barcodes on each bag of medicines to enter them on to an online delivery application. This then organised their route and provided an audit trail for the deliveries made. This also listed the medicines that were being sent out as well as highlighting any fridge items or CDs. Some deliveries were posted through people's letterboxes. The SI explained that this was done only after jointly considering the risks with those people who requested it. And they demonstrated how people's records were annotated to show that this had been done, as well as how this information was displayed to the delivery driver. The driver returned any failed deliveries back to the pharmacy on the same day.

The pharmacy provided medicines in multi-compartment compliance packs for a large number of people. Team members ordered prescriptions in advance of the compliance pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any queries. They also kept an audit trail of which ordered prescriptions had been received back to easily highlight if any were outstanding. The pharmacy used a record for each person that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs. From a sample of compliance packs checked, the full dosage instructions, and medication descriptions were included. And patient information leaflets were routinely supplied. However, the recommended warnings for the medicines contained were not always included which meant people may not always know about precautions they may need to take. The SI understood the importance of these warnings and agreed to make sure they would always be included in future. The pharmacy team used a designated area of the premises for the storage of the large number of assembled multi-compartment compliance packs. The pharmacy dispensed medicines for a number of care homes. Team members undertook work relating to care homes in a separate area from the main dispensary. The team members working in this area also produced Medicines Administration Record (MAR) charts to accompany the medicines they dispensed for care home residents. These allowed care home staff to record when doses of medicines had been taken. To support the accuracy of medicines administration, the dispensing labels produced by the pharmacy for the care homes contained a unique barcode. The barcodes allowed an application to provide an accuracy check prior to the administration of a medicine in the care home. And it allowed care home staff and pharmacy team members to monitor the

quantities of medicines that people had remaining.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Pharmacy team members signed dispensing labels during dispensing and checking, to maintain an audit trail of the team members involved in the process. They used stickers to highlight prescriptions that contained fridge items, to ensure correct storage temperatures were maintained. And they highlighted prescriptions that contained CDs to ensure they were stored securely. The pharmacists provided counselling over the phone when supplying some higher-risk medicines to people. They counselled people receiving prescriptions for valproate if they were at risk. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. The SI demonstrated examples of patient records that had been annotated to show when discussions had taken place with people or their representatives to support the safe supply of valproate and medicines with similar risks. The pharmacy offered to provide the NHS New Medicines Service whenever appropriate, as a structured way of supporting people who were prescribed new medicines. Records of the different consultation stages were kept on the PMR.

The pharmacy kept any prescriptions awaiting stock in a designated part of the dispensary. Team members promptly informed people if supply difficulties meant they could not supply their medicines. The pharmacy had a procedure for checking expiry dates of medicines. Team members checked defined sections of the dispensary and recorded when the expiry dates of medicines in a section had been checked. And they explained how they had recently become more vigilant to the expiry dates on new stock received, after some orders received contained stock with short dates. Evidence was seen of medicines highlighted due to their expiry date approaching or because the shelf life was reduced after being opened. Unwanted medicines that had been returned by people were kept in segregated containers, while awaiting collection for disposal.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. Medicines requiring cold storage were kept in two medical fridges equipped with thermometers. Team members monitored and recorded the temperatures of the fridges regularly and the records showed the temperatures had remained appropriate. The pharmacy held its CDs in secure cabinets. It had a documented procedure for responding to drug safety alerts and manufacturer’s recalls. It received these via email and had records of alerts received and any actions taken in response.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people’s private information.

### Inspector's evidence

Pharmacy team members had a range of hard-copy reference materials and access to the internet for up-to-date information and further support tools. And they had specialist software to support them safely supplying medicines to care homes. There was equipment available for the services provided. Electrical equipment was visibly free from wear and tear and appeared in good working order. The pharmacy had a range of clean counting triangles and CE marked measuring cylinders for liquid medicines preparation. The team used separate equipment when counting and measuring higher-risk medicines. They used personal protective equipment, such as disposable gloves, when handling medicines and performing some other tasks.

The pharmacy's computers were password protected and access to people's records was restricted by the NHS smart card system.

## 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. |