General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bliss Pharmacy, 107-109 Gloucester Road, LONDON, SW7 4SS

Pharmacy reference: 1093221

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

The pharmacy is located on a busy high street in an affluent area in West London. And it serves a large number of tourists. The pharmacy does not have an NHS contract and only dispenses private prescriptions. It also sells over-the-counter medicines and provides blood pressure measuring and blood glucose testing services. The pharmacy also offers beauty treatments including laser hair removal. Both regular pharmacists are independent prescribers.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not identify and manage all the risks involved with its service. For example, people are prescribed a wide range of medicines and there are not always audit trails to support the decision to prescribe. And the pharmacy does not undertake any risk assessments of the prescribing service.
		1.2	Standard not met	The pharmacy does not properly review its prescribing services to make sure that they are safe for people to use. The prescribers keep their consultation notes separate from each other. So, they cannot easily access all the information they need to about previous consultations with people. And it this could make it harder for them to review the prescribing.
		1.6	Standard not met	The pharmacy does not consistently keep and maintain records of clinical decisions. And it does not always ensure that the records in the private prescription register are accurate or complete.
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 not all met	4.2	Standard not met	The pharmacy does not always provide its services safely. It provides its services without always having reliable audit trails for them. It does not always fully complete patient records on all occasions and notes made are not always available to the prescriber for follow-up visits
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not manage and identify all the risks associated with the prescribing service it provides. There is an incomplete audit trail to demonstrate what consultations have been held before making a decision to prescribe. The pharmacy does not consistently keep and maintain records of clinical decisions. People using the pharmacy can provide feedback. And team members know how to protect vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. But they do not always record mistakes that happen, so they might be missing opportunities to learn and make the services safer.

Inspector's evidence

The initial inspection was undertaken on 6 February 2020, with a follow-up visit on 20 February 2020. The regular pharmacist was present on the initial inspection, and the superintendent pharmacist (SI) was present on the second visit.

Standard Operating Procedures (SOPs) were up to date. These had recently been implemented by the responsible pharmacist (RP). Team members were in the process of reading and signing these. An SOP was in place for the independent prescribing service. This had been put in place by the superintendent pharmacist (SI) and at the time of the inspection had not been updated following the updated guidance released by the GPhC for pharmacist independent prescribers. Team roles were defined within the SOPs. The previous version of SOPs was stored in the dispensary, this could lead to confusion as to which SOPs were in place and current.

Near misses were not routinely documented; the last recorded near-misses observed were from May 2019. Team members said that there had probably been some near misses in this period which had not been recorded. Near misses were discussed with the team. To reduce the risk of mistakes the team had made a number of changes which included taking more time when preparing labels, tidying up more frequently and reorganising the dispensary. The RP explained that the pharmacy was not as busy as they had lost a contract with one of the embassies. This was seen during the inspection with no prescriptions being dispensing during the whole inspection.

Dispensing incidents were recorded on a specific form which was available at the pharmacy. As a result of a past incident in which a medication had been supplied against an expired prescription the pharmacists now carried out a clinical and legal check before the prescription was handed to the dispensers to dispense.

The correct responsible pharmacist (RP) notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The RP confirmed that this also covered the prescribing aspect of the service.

The complaints SOP could not be located, and the RP (who was the regular pharmacist) agreed to forward this to the inspector. Members of the team said that customer feedback forms were normally available, but the pharmacy had run out of these at the time of inspection. Team members were not aware of any recent complaints or feedback.

The private prescription register was held electronically. Samples of the register were not always fully complete; some prescriber details were either missing or incorrect. Some private prescriptions were missing patient addresses. Emergency supplies were not provided at the pharmacy; medicines were independently prescribed by the pharmacists. Records for unlicensed specials dispensed, RP records and CD registers were well maintained. Regular CD balance audits were mostly done regularly for some CDs, but not for all. A random stock check of a CD agreed with the recorded balance. Expired stock was kept in a labelled plastic bag and separated from in-date stock.

Each prescriber had separate consultation forms, this required details of the person's regular doctor, medication history, allergies, family medical history and presenting symptoms. Forms were not used on every occasion; this was seen during both visits. Only two completed forms were seen in the superintendent pharmacist's (SI) folder; this was not reflective of the number of prescriptions issued by him in 2020 as a greater number of prescriptions were seen. The regular pharmacist had issued fewer prescriptions but had completed far more consultation forms.

The SI explained that this was because consultation forms were only completed when treatment was initiated; but a vast majority of prescriptions issued by both prescribers was continuing treatment that the person had been started on by their usual doctor, or if someone had forgotten or lost their medication whilst travelling. Evidence of previous prescribing was always requested, seen and noted before prescribing was carried out. The SI added that many people using the pharmacy were from the Middle East and preferred to get their medicines from the UK as they believed the quality was superior to that of their native countries. Also, some of the medicines prescribed were not available or out of stock in the person's home country. People were counselled on the importance of regular health check-ups and blood tests (thyroid, kidney, liver and heart function tests) with their regular prescriber and evidence of this was seen to be recorded at the back of some prescription forms during the second visit. The SI described that following the first inspection visit both prescribers had started ensuring that records were made for each consultation carried out in which a prescription was issued. The duration of treatment prescribed varied with one example seen where someone had been supplied with a years' worth of medicines but had been counselled to see their prescriber. Other prescriptions quantities ranged from one month to three months. In some cases, copies of people's prescriptions from their regular doctor or medical history notes were attached to the prescription. On a number of forms, it was observed that the prescribers had communicated with the person's specialist or regular prescriber. However, information was not consistently recorded on all prescriptions issued by both prescribers. Examples of some prescriptions were seen where no records had been made, but the SI was able to provide evidence of records seen after speaking to the second pharmacist. Notes were made on individual prescriptions which were filed at the end of each month. Any information recorded on these would not be visible to prescribers the next time the person visited the pharmacy.

Most completed consultation forms that were seen had no record of what investigations had been carried out, record of red flags or discussions. On some occasions there was also no information about the patient's medical history or presenting symptoms. Completed forms were also filed all together in order of date completed. Each prescriber had their own individual folder. So, notes from previous consultations may not be available to the other prescriber on future consultations.

Consultation forms were kept separately from the prescriptions. There was some evidence that details of the person's regular prescriber had been obtained, and in some cases copies of prescriptions issued abroad were also retained. However, these were not always in English. The pharmacy did not contact people's usual prescriber to inform them of the supply; however, a vast majority of the people using the pharmacy were from other countries. Some of the prescriptions included information about the clinical decision to prescribe the medicine. But not all of them did, and information about this decision was not always recorded. And this could make it harder for the pharmacy to show why a medicine was

prescribed.

Several incomplete prescriptions were seen. This included prescriptions without a signature and also prescriptions missing a date of birth or the age of the person. The age of the person would be required in the event that a prescription was for a child under 12 years to confirm the correct dosage. Some of the handwriting seen on prescriptions was also observed to be different to the prescribers handwriting. The RP said that these would have been written by one of the dispensers following the consultation with the prescriber.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. They do the right training so that they know how to provide the pharmacy's services. They have regular catch-ups and they are asked about how they would like to progress and gain new skills.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP and two trained dispensers both of who were enrolled on the NVQ level 3 course. Another team member covered the medicines counter but only dealt with retail sales and the nutrition side of the business. She had not completed any accredited pharmacy courses but did not sell any medicines and referred to either the RP or one of the dispensers. The RP usually covered the full shift which was approximately 13 hours. He described having a short break and said that the pharmacy was not very busy. The pharmacy was observed to be quiet during the inspection.

Annual and emergency leave was covered internally. There was a structured rota in place; members of the team were either planned in for the 9am to 5pm or the 2pm to 10pm shifts. There was at least one pharmacist and one dispenser at any one time in the dispensary.

The dispensary manager described her responsibilities. These included helping with dispensing, managing queues, maintaining stock levels, managing accounts, supervising the ordering of over the counter and retail products and dealing with complaints. The pharmacists liaised with embassy doctors and occasionally issued prescriptions for people following the conversation.

Appraisals were conducted once a year. Team members were provided with feedback during the appraisals and worked on what they needed to improve. During the conversation they were also able to feedback on changes they had made or any changes which they would like to see. This was then reviewed at the next appraisal.

Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. They would always refer to the pharmacist if unsure or for any requests for multiple sales.

Both regular pharmacists who worked at the pharmacy were independent prescribers. The RP's area of competence included skin infections, eczema, minor ailments, respiratory infections and urinary tract infections. The RP also worked as on oncology pharmacist in a hospital and was working towards gaining a diploma. A number of prescriptions for people issued by the prescribers were repeat medicines. The RP estimated that approximately 80% of these people were not from the UK. This was evident from the prescription forms seen during the visit.

The SI's area of expertise when he had completed the course was diabetes and the RP said that he had extended this to asthma, neuropathy and had completed a course in phlebotomy. This was confirmed by the SI. Neither pharmacist had any evidence of training completed. The pharmacy was due to launch a phlebotomy service by this had not been implemented at the time of the inspection.

The RP and superintendent pharmacist (SI) said that they had both completed courses for various

clinical aspects linked to their prescribing. Neither prescriber had a folder or any evidence to prove their competency in the varied areas they were prescribing; such as certificates of courses completed or attended. The SI was a member of Belmatt healthcare training, which organised numerous events for non-medical prescribers, which he regularly attended. He had also subscribed to the Prescriber Journals over the last two years which he received on a monthly basis to keep up to date with numerous topics and prescribing guidelines.

Other team members were provided with training for new products and nutritional training. Previously each individual was given training time on a monthly basis but this had been changed to alternate months. The latest training completed had covered probiotics. Training records were not maintained at the pharmacy. Making sure that some of the revalidation records directly addressed the role of a pharmacist prescriber was discussed with the RP.

Daily meetings were held to discuss targets, issues, concerns and workload. The pharmacists used a communication book to share information and saw each other once a week on Friday when there was an overlap.Daily sales targets were set for the team, but they felt these targets were reasonable and did not affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and bright. The dispensary, which was located to the rear of the shop, was relatively small and comprised one long workbench and storage shelves. There was limited work and storage space; bags of medicines awaiting collection were kept on the dispensary floor. There was no sink fitted in the dispensary, but team members used the sink inside the consultation room and distilled water was used to reconstitute antibiotics. A store room was located in the basement; excess stock was stored in this room. The room was also used for the company's online business which did not include supplying any medicines.

A consultation room was available which was clean and tidy. The room was shared with the beautician and was seen to be used by them for long periods of time during the inspection. In the event that the RP needed to have a private conversation with someone whilst the room was in use, he would take them to a quiet area of the shop. The pharmacy was not seen to be busy during the course of the inspection. In some cases when the consultation room was occupied verbal consultations were carried out on the shop floor prior to a prescription being issued and dispensed.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always provide its services safely. It provides its services without always having reliable audit trails for them. It does not always fully complete patient records on all occasions and notes made are not always available to the prescriber for follow-up visits. However, the pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts. People with a range of needs can access the pharmacy's services.

Inspector's evidence

Access into the pharmacy was via a small step; members of the team described helping who required assistance. Team members were multilingual and translated for customers when needed. Pharmacy services were advertised on the pharmacy's website and on a screen in the pharmacy. Team members signposted people to other service providers if a service was not available at the pharmacy. The team gave an example of referring people to an NHS pharmacy across the road when needed.

A double-check of the dispensed medication was obtained the majority of the time, with pharmacists not frequently having to self-check. The dispenser assembled the medicines and placed them in baskets which were put aside to be checked by the pharmacist. When pharmacists issued prescriptions they were then dispensed by the dispenser and checked by the prescribing pharmacist.

Dispensing audit trails were not maintained to help identify members of the team involved in dispensing and checking prescriptions. This could make it harder for the pharmacy to identify who did which task if there was a query. Owing slips were generated for part-dispensed prescriptions and provided to people.

In some cases, NHS prescriptions were dispensed as private prescriptions. The RP explained that this was only done when the pharmacy across the road was either closed or did not have the items available in stock. In these cases, people were generally charged a flat rate. Some prescriptions from outside of the UK were transcribed by the prescribers.

Medicines which had been prescribed and dispensed included but was not limited to candesartan, metformin, enalapril, melatonin, prednisolone, rivaroxaban, statins, proton pump inhibitors, Entocort, antibiotics, anti-inflammatories, steroids and methotrexate. Additionally, prescriptions for pregabalin were also seen; these were issued on the standardised forms used for private CD prescriptions. The RP said that they would never initiate a high-risk medication but only initiate medication for minor ailments. This was reiterated by the SI who described that neither pharmacist initiated treatment except to treat suspected bacterial infections such as urinary or chest infections.

As part of the consultation before prescribing antibiotics, the RP described how he carried out a swab test for throat infections. He used an electronic online application which showed the antibiotic guidelines from around the world. Antibiotics were prescribed in line with people's country of origin unless they had stayed in the UK for longer than four weeks in which case the RP used UK national guidelines. The RP also had a stethoscope which he used to listen to the person's chest. In addition to this he also checked the temperature and looked for signs of infection. Details of assessments carried out were not always recorded. The SI carried out a similar examination and recorded details of

observation on the prescription forms in some cases.

If people required monitoring or blood tests as part of their treatment they were handed records of what had been prescribed to give back to their usual prescriber. The RP occasionally prescribed Botox for people after carrying out a face-to-face consultation. This was administered by a trained doctor who was based elsewhere.

The pharmacy did not routinely record monitoring parameters for people on higher-risk medicines. Warfarin was not frequently dispensed, but there was evidence that methotrexate had been prescribed for someone who had lost their medicines. One person was supplied warfarin which was collected by their driver, and no checks were carried out as to whether the person was having regular blood tests; the prescription had been issued by another prescriber and dispensed by the pharmacy. The RP described calling children's parents to check for allergies when nannies presented to collect a prescription.

A prescription was seen from June 2019 for an antibiotic for a person with a history of taking an immunosuppressant medicine, 'to prevent worsening of cold or flu symptoms'. No dose was stated on the consultation form, neither was the duration of treatment or frequency. There was no further documentation of any investigation carried out.

A number of private-prescription records were seen to be for medicines liable to abuse, overuse or misuse, or where there was a risk of addiction and ongoing monitoring is important. For example, opiates and sedatives. A number of the private prescription records for these entries did not have details of the prescriber recorded. So, it was unclear as to where the prescription had originated from or if these had been prescribed in-house. From a sample of prescriptions issued by both prescribers, prescriptions were seen to be prescribed for this group of medicines. The SI described that in most cases the person was supplied with only one months' worth of the medication, although this was not always seen to be the case. The SI also said that if a repeated pattern of request was identified by either of the prescribers they informed the other and the person was not prescribed any further medication. In a number of cases people who were prescribed opiate based pain-relief or sleeping aids were under the care of a specialist in their home country. The pharmacy did not have a written policy in place for the supply of these medicines.The RP was aware of the change in guidance for dispensing sodium valproate. Members of the team had read the valproate guidance. The pharmacy did not have many people who were supplied valproate and did not have anyone who fell in the at-risk group.

The details of people's usual prescriber had been obtained for some of the records of prescribing seen. And in some cases, a copy of the original overseas prescription was present. But people's usual prescribers were not routinely informed of a prescription issued by the pharmacy. However, this may have been difficult given that many people's prescribers were based in other countries. As detailed in Principle one, the pharmacy did not always keep an audit trail for its prescribing service. Consultation notes and clinical reasons for prescribing were not always complete. And notes of previous consultations were not always available to prescribers.

Stock was received from licensed wholesalers. Date checks were conducted on sections of the dispensary every one or two weeks, a date-checking matrix was in place. Short-dated medicines were seen to be marked with a coloured sticker. There were no expired medicines found on the shelves checked. Some medicines were found on the dispensary shelf in an amber bottle. The batch number had not been recorded on the bottle. The medicine was disposed of during the inspection. Fridge temperatures were monitored and recorded for three of the four fridges, temperatures were seen to be within the range required for the storage of medicines. The temperature for the fridge on the shop floor was not monitored and this was mainly used to store supplements. Some chloramphenicol

eyedrops had been placed in this fridge but were moved by the dispenser when it was brought to her attention. The temperature reading for one of the fridges in the basement was initially out of the required range for the storage of medicines. However, after resetting the probe the temperature returned to the required range.

The pharmacy was compliant with the falsified medicines directive. SOPs had been updated to incorporate this. The pharmacy had a contract for waste medicines but it did not receive patient-returned medicines; people were signposted to the pharmacy across the road.

Drug alerts and recalls were received from the MHRA or directly from the wholesalers. Alerts were checked by the dispenser on duty.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Equipment was clean and in good order. Measuring cylinders, tablet and capsule counting equipment were clean and ready for use. A separate triangle was available and used for cytotoxic medication. Up-to-date reference sources were available including access to the internet. Three fridges of adequate size were available. The blood pressure monitor was said to have been calibrated since the last inspection and the blood glucose monitor was replaced annually. Computers were password protected and screens faced away from people using the pharmacy. Confidential waste was segregated and collected by an external company for destruction.

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.