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: 28/05/2021

Pharmacy context

The pharmacy is located on a busy high street in an affluent area in West London. It normally serves a large number of tourists, but most people have returned to their country of origin due to the Covid-19 pandemic. The pharmacy is now delivering most of its medicines via courier. The pharmacy does not have an NHS contract and only dispenses private prescriptions. Both regular pharmacists are independent prescribers. The pharmacy has had to suspend some services, such as blood pressure measuring and blood glucose testing, due to the pandemic. The inspection took place during the Covid-19 pandemic, and was undertaken both virtually and face-to-face. The face-to-face inspection took place on the date of this report.

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 prescribes medicines to people overseas. But it does not sufficiently identify and mitigate the risks associated with this service.
		1.5	Standard not met	The pharmacy has current indemnity insurance. But it doesn't always ensure that its policy provides appropriate cover when its services change.
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 not all met**

Summary findings

The pharmacy doesn't adequately identify and manage the risks associated with its services. It prescribes medicines to people overseas, but it does not sufficiently identify the risks associated with this service. For example, the risk assessment does not cover the range of the medicines the pharmacy prescribes and supplies to people overseas. The pharmacy has current indemnity insurance, but it does not always ensure that its policy provides appropriate cover when the pharmacy's services change. However, the pharmacy generally keeps the records it needs to by law. People who use the pharmacy can provide feedback and raise concerns and the pharmacy team have received some training to help protect the welfare of vulnerable people. Team members generally respond appropriately when mistakes happen during the dispensing process. Prescribing audits are not always clear about some details, which may make them less constructive.

Inspector's evidence

The inspection was conducted virtually and face to face by two inspectors and a clinical advisor, with the superintendent pharmacist (SI) and second regular pharmacist attending.

Covid-19 risk assessments had been conducted and recently reviewed, including staff-specific risk assessments. These were seen to be thorough. The SI said he had wanted to change the number of people allowed into the pharmacy at the same time as some people were not following the safe distancing guidelines. Team members' temperatures were checked daily and all members of the team wore a face mask and visor. People were also asked to wear a face mask before entering the pharmacy.

The pharmacists said that they mainly prescribed for people who had already been diagnosed and prescribed medicines by their regular prescriber. The SI said that approximately 80% of prescriptions issued by the pharmacists were for regular patients living abroad who wanted their medicines from the UK. And the rest were for people who came into the pharmacy. Most of the people living abroad were seeing doctors in their home countries. People sent the pharmacy a copy of the prescription from their usual prescriber by email. To verify the authenticity of the prescriber of the original prescription, the pharmacists contacted overseas clinics using the contact details found on prescriptions. However, this relied on the number on the prescription being accurate and therefore may not be a robust method. There was also some risk that people could have the original prescription dispensed in their home country, obtaining more medication than was intended, as the pharmacy did not always contact the originating prescriber. Both of these issues were discussed with the pharmacists during the inspection.

A range of medicines were seen to be prescribed by the pharmacists, such as Otomize ear spray, amoxicillin, folic acid, lamotrigine, azithromycin, co-proxamol, risperidone, domperidone, vitamin D, and contraceptive pills. Some of these were medicines for specialist conditions such as epilepsy, cancer, mental health and fertility. The SI and second pharmacist audited each other's prescribing. A copy of a recent audit was sent to the inspector following the virtual inspection. However, the audit was lacking some useful details. It was unclear about the number of prescriptions sampled (the audit stated 'a handful'). It could have been clearer about the pharmacists working in line with guidance and the parameters the SI was auditing against. Although it stated that the pharmacists worked within local guidance, it was not clear which guidance, and these did not necessarily apply to people in their own country.

Prior to the pandemic, the pharmacy had mainly prescribed medicines for people who came into the pharmacy. But during the pandemic, many of the people had returned to their own countries. And so, the pharmacy was often providing its prescribing service remotely. The pharmacy had made a risk assessment document for the overseas prescribing service, but, it was not comprehensive. The risk assessment described 'prescribing for overseas/embassy patients' as a risk, but it did not elaborate further on this or list potential risks of this service. Or how the pharmacy would mitigate any associated risks. The pharmacy prescribed a wide range of medicines. And the risk assessment did not cover all the medicines supplied, as well as other risks, such as checking the authenticity of the original prescriber or minimising the risk of people being able to use their original prescription to obtain an additional supply in their own country. High-risk medicines were mentioned, but it was not clear which medicines the pharmacy considered as high risk. Numerical risk ratings were assigned to the overseas prescribing service on the risk assessment, but the pharmacist was not entirely sure how these risk ratings were obtained.

Standard operating procedures (SOPs) were up to date. Team roles were defined within the SOPs and team members had read and signed the relevant SOPs. An SOP was in place for the independent prescribing service and this had been reviewed by the SI who had taken into consideration changes to practice due to Covid-19. For example, pharmacists were now reviewing whether a face-to-face consultation was necessary, and if it was, they would screen people for Covid-19 symptoms and check their temperature. The consultation room would also be cleaned after every person. The previous version of the SOPs was no longer stored in the dispensary, to avoid confusion as to which SOPs were in place and current.

The SOP covering independent prescribing had been reviewed and updated. The pharmacy also had a prescribing policy but it was not comprehensive. Although the policy stated that prescribers would comply with guidance, it did not specify which guidance. It did not cover the medicines prescribed, any maximum supplies within a given time frame or any monitoring required.

Dispensing mistakes which were identified before the medicine was handed to a person (near misses) were documented. Near misses were discussed with the team but were not formally reviewed. So, the team might be missing opportunities to learn and make the services safer. To reduce the risk of mistakes the team had been asked to take their time when dispensing. The SI also described a near miss where the person collecting was talking on their telephone and so, their name had not been confirmed properly. Team members had identified the mistake before handing over the medicines. As a result, the SI had briefed all members of the team to wait until a person had finished their call before handing out medicines.

Dispensing mistakes where the medicine had been supplied to a person (dispensing errors) were documented on a community pharmacy medication safety incident report form. The SI was advised to review the medicine handout SOP after describing a near miss and a dispensing error involving the hand-out of medicines.

The correct responsible pharmacist (RP) notice was displayed. The RP record was generally well maintained. The pharmacy had current professional indemnity insurance. The SI confirmed that this also covered the prescribing aspect of the service. However, since the start of the pandemic the pharmacists were now prescribing and supplying medicines for people overseas, and the policy did not cover this. Following the inspection, the SI had arranged for additional cover and confirmed that this part of the service was now covered.

The private prescription register was held electronically. Samples of the register examined were complete. The SI said that a dispenser reviewed entries every month and raised any issues with the

team. Emergency supplies were not provided at the pharmacy and medicines were independently prescribed by the pharmacists. Records for unlicensed specials dispensed were not always completed in line with MHRA guidance. Some certificates of conformity could not be found whilst others were not filled in. A random stock check of a controlled drug (CD) agreed with the recorded balance in the CD register. Expired CD stock was kept in a labelled plastic bag and separated from in-date stock. Destruction of CDs which had been returned by people was entered into a register.

Consultation notes and copies of evidence obtained (for example, prescriptions from foreign doctors), were retained in one folder. Prescriptions generated by the pharmacists were kept in another folder. Both folders were stored securely. One dispenser was responsible for reviewing notes and prescriptions every month to check for missing items or incomplete information. Both prescribers were reviewing each other's prescriptions every quarter. They checked if each other's notes were complete, monitoring parameters had been noted, counselling was provided, and references used, such as published guidance.

A complaints procedure was in place. Members of the team said that they would refer people to the pharmacists if they wished to raise a complaint. The SI described an occasion where he had been concerned about a potential interaction when a person came in to buy an over-the-counter medicine. The person had then requested the manager’s contact details, which the SI had provided. The SI had explained to the person that he had needed to check as there could be an interaction with the medicine requested.

All team members had completed online training and multiple-choice questionnaire on the General Data Protection Regulations. Confidential waste was shredded, and computers were password protected. Confidential information was not visible to people visiting the pharmacy.

Both pharmacists had completed the safeguarding course from the Centre for Postgraduate Education (CPPE). Team members had been briefed about safeguarding and told to raise any concerns directly to the pharmacists. When asked about how he would raise safeguarding concerns involving patients living abroad, the SI said he would contact the relevant country’s embassy.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members do some ongoing training so that they know how to provide the pharmacy's services safely. The pharmacy has enough team members to manage its workload. But team members do not all start or finish accredited training in a timely manner.

Inspector's evidence

The pharmacy team comprised of two regular pharmacists (one was the SI), a dispenser, an accuracy checking technician (ACT), a trainee technician, a retail assistant and another assistant covering the medicines counter. The SI was not entirely sure if the assistant covering the medicines counter (and who was involved in selling Pharmacy-only medicines) had completed the relevant training. She had been working at the pharmacy for approximately two years. Following the inspection, the SI confirmed that the assistant covering the medicines counter had not completed the relevant training and that she had since enrolled onto a medicine counter assistant course.

The pharmacy was open seven days a week but opening hours had been reduced to 9am to 8pm (rather than 10pm closing time) due to the pandemic. A rota was in place and there was always at least one pharmacist and one dispenser covering a shift.

The second regular pharmacist was also the dispensary manager. He was responsible for organising the staff rota, checking the near miss log was being filled in, and setting tasks such as expiry date checks.

Annual and emergency leave was covered internally or by staff from another branch. Regular locum pharmacists were also available to cover though they were not independent prescribers. The SI said they would contact him if this service was needed and he would either signpost the person to another prescriber or book a consultation on another day.

The SI said that he encouraged team members to complete ongoing training and requested training certificates, though there was little evidence available of any recent training being conducted. Team members did not have allocated study time and training records were not maintained at the pharmacy. The team had access to pharmacy magazines and online resources. Following the virtual inspection, the pharmacist said that group meetings were being held to discuss 'hot topics' such as hay fever. The pharmacy was planning on holding these monthly, with varying subjects to discuss, according to changes or training needs.

Both regular pharmacists who worked at the pharmacy were independent prescribers. The SI's area of expertise when he had completed the course was diabetes, but he now specialised in acute infections. The second pharmacist's area of competence was initially the cardiovascular system but said he was now mainly prescribing for minor ailments. The second pharmacist said that he had wanted to complete a community diploma, but this had been put on hold due to Covid-19. He attended webinars, for example, on opioid dependence, and had completed aesthetics training. But he had not practiced in aesthetics due to Covid-19. The SI was a member of a healthcare training provider, which organised numerous events for non-medical prescribers. The prescribers also discussed case studies on an electronic messaging application and shared quizzes and other learnings. The SI also subscribed to the Prescriber Journals to keep up to date with numerous topics and prescribing guidelines.

Appraisals were conducted once a year. The SI said that the team communicated together and shared information on a telephone messaging application to ensure they were all up to date. Sales targets were no longer set for the team.

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, but workbenches were kept clean and tidy. There was no sink fitted in the dispensary. Team members used the sink inside the consultation room and distilled water was used to reconstitute antibiotics. A storeroom was located in the basement and was used to store excess stock. 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 allowed a conversation at a normal volume to take place inside which would not be overheard. The SI said the team tried to avoid using the room due to Covid-19, but they would maintain a safe distance if it was necessary to use it. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. There were floor markings and signs on the door to remind people to maintain a safe distance. The pharmacy was also limiting the number of people allowed in at the same time.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely and maintains clear audit trails for its prescribing service. It obtains its medicines from reputable sources and manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts. However, the systems it uses to verify the authenticity of overseas prescribers could be more robust.

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 pharmacy was selling Covid-19 home testing kits. The SI said he had contacted the National Pharmacy Association (NPA) and read the government's guidance on Covid-19 testing. He explained that he would signpost people to the pharmacy's other branch for 'fit-to-fly' tests.

A double-check of the dispensed medication was obtained the majority of the time. The dispenser assembled the medicines and placed them in baskets which were put aside to be checked by the pharmacist. Prescriptions issued by the pharmacists were dispensed by the dispenser and checked by the prescribing pharmacist.

Approximately 25% of prescriptions dispensed at the pharmacy were independently prescribed by the pharmacists. As most of the pharmacy's regular patients had moved back to their country of origin, more medicines were now sent by courier. And the pharmacy only offered its prescribing services at a distance to people who had previously been coming into the pharmacy. And so, the prescribers were familiar with these people and their medical history. The pharmacy obtained consent to send peoples' medicines by courier verbally. The pharmacy checked with the NPA and the relevant embassy before sending medicines by courier. People normally requested their medicine one month in advance to allow time for the medicine to be prepared and shipped. Medicines requiring cold storage and liquids were not sent by courier. The medicines were wrapped in bubble wrap, packaged in cardboard boxes and sealed with tamper-evident tape.

The SI said he checked if medicines were accepted in the country of delivery. The pharmacists said that CDs were not prescribed or sent via courier. The pharmacists said they were no longer prescribing benzodiazepines or 'Z-drugs' as they had found that most patients could not provide a prescription from their doctor. However, from the private prescription records, it appeared that a very small number of Schedule 4 CDs had been prescribed. The SI said these were one-off supplies, which were no longer being prescribed.

Consultations were still conducted by the pharmacists, even when a prescription from a doctor was seen. The SI said he contacted these people to check for monitoring parameters and any changes, as well as to provide counselling. The SI explained that high-risk medicines were never initiated by the pharmacists and were only prescribed if a copy of the prescription from the patient's doctor was

provided.

The pharmacist prescribers did not routinely share information with the patients' doctors as most were abroad. The SI said they verbally advised people to update their doctors. This method may not be sufficient as it relies on patients' to appropriately understand what needs to be communicated and liaise any follow up and monitoring. The pharmacists said they would try to contact the prescriber directly, if consent was obtained from the patient.

Monitoring parameters were seen to be recorded on the patient medication record system. The SI described refusing to supply lithium to a patient in Kuwait. The patient had then provided their recent blood test results, which were documented at the pharmacy, before a supply was made.

Both pharmacists were aware of labelling requirements and counselling points to provide when supplying sodium valproate to people in the at-risk group. Safety cards and warning labels were available at the pharmacy.

Antibiotics were seen to be prescribed for people living abroad. The SI said that he did not check the antibiotic guidance of the person's country of residence as they did not necessarily align with the UK guidelines. The SI said he followed only UK and NICE guidance when prescribing. He provided an example of when antibiotics were not prescribed, for example, a person presenting with a sore throat but no other symptoms. People were asked to do a urine dipstick test before the pharmacists prescribed antibiotics for urinary tract infections (UTIs). The SI described prescribing only three-days' worth of nitrofurantoin for a person who was in pain due to recurring UTI. He had spoken to her regular pharmacist to confirm previous supplies and had signposted her back to her GP for a urine test.

Stock was received from licensed wholesalers. Date checks were conducted every month and a date-checking matrix was in place. Short-dated medicines were separated from stock and stored in a box. Fridge temperatures were monitored and recorded for three of the four fridges, temperature records examined 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 although it was used to store supplements requiring cold storage. This was discussed with the pharmacist at the time of inspection. CDs were stored securely.

Drug alerts and recalls were received from the MHRA or directly from the wholesalers. Alerts were checked and shared with the team on the telephone messaging application.

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 were available. The blood pressure monitor, temperature readers and oximeters were all labelled with the dates of first use. The SI said this equipment was replaced or calibrated regularly. Computers were password protected and screens faced away from people using the pharmacy. Confidential waste was shredded at the pharmacy.

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.