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: 08/09/2023

Pharmacy context

This is a community pharmacy on a busy road in London. It offers a range of private services including prescribing and skincare and beauty products. It also dispenses private prescriptions. It does not provide NHS services. Most of the people using the pharmacy are visiting the UK from overseas and come into the pharmacy in person. The pharmacy no longer sends any medicines abroad.

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 cannot sufficiently demonstrate that it has appropriately considered the risks associated with its prescribing service. It has not done a risk assessment for this service. And it has not appropriately considered the risks of not informing the person's regular prescriber when prescribing medicines for conditions which require ongoing monitoring.
		1.2	Standard not met	The pharmacy cannot sufficiently demonstrate that it monitors the safety and quality of its prescribing service, for example by undertaking regular clinical audits.
		1.6	Standard not met	The pharmacy does not always make appropriate consultation records for its prescribing service, so it is harder for it to demonstrate why a prescription was issued.
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 cannot sufficiently demonstrate that it has appropriately considered the risks associated with its prescribing service. For example, it has not undertaken a risk assessment for this service. Or appropriately considered the risks of prescribing for long-term conditions without informing people's regular prescriber. It does not monitor the safety and quality of its prescribing service, for example by undertaking regular clinical audits. It does not always make appropriate consultation records for its prescribing service, so it is harder for the pharmacy to show why some prescriptions were issued. However, the pharmacy generally keeps its other records in line with requirements. And people can provide feedback or raise concerns. Team members protect people's personal information well. And they know how to protect the welfare of vulnerable people.

Inspector's evidence

The superintendent pharmacist (SI) said that the pharmacy had stopped supplying medicines overseas and was receiving more prescriptions from external prescribers. The pharmacy offered a prescribing service (the SI was the main prescriber), but the number of prescriptions issued was relatively low compared to the number of external prescriptions dispensed. The pharmacy also employed another pharmacist independent prescriber (PIP), who worked part time. The SI explained that this PIP did not initiate any new medication. But they would issue prescriptions for a number of conditions where the person was able to demonstrate with evidence that they were already prescribed this medication by their original clinician on a continued basis.

The SI explained that she was qualified to initiate treatment for skin and some minor conditions. Following the inspection, the SI provided her own individual prescribing framework which detailed the clinical conditions she could prescribe for, and which medications. But there were no written risk assessments or pharmacy policies available to reflect this or for the pharmacy's in-house prescribing service as a whole. And there was no assessment to identify and mitigate any risks of having one person prescribe, dispense, clinically check, and accuracy check a prescription.

The pharmacy could not demonstrate that it had fully considered the other risks associated with the pharmacy's prescribing service. For example, the people using the prescribing service were often based abroad and were visiting the UK. And this meant that the PIP sometimes prescribed outside UK guidelines, and the potential risks of this had not been considered.

The SI explained that the pharmacy mainly prescribed for people visiting the UK from overseas. Medication for these people was prescribed for them based on continuing medication that they were already taking. Some of this medication was for conditions which required ongoing monitoring, such as cardiovascular conditions and diabetes. The SI explained that a repeat medication slip, empty medication packs or clinical letters were used to assure her that the person had been prescribed it previously, but this evidence was not always documented. The pharmacy team did not make attempts to independently verify this information by contacting a person's usual physician and did not notify them of a new prescription that had been issued. So, the person's original prescriber may not be aware that a person had been supplied medicines for a condition which required ongoing monitoring. And there was no documentation to demonstrate that the pharmacy had considered the potential risks of this. From the private prescription records seen, there was no evidence to show that the pharmacy

prescribed medications more than once to people with ongoing conditions which required monitoring.

The SI explained how the pharmacy team had regular discussions about the prescribing service, but these discussions were not formal or documented. There had been no clinical audits about any of the therapeutic areas the pharmacy prescribed in since September 2021. This made it harder for the pharmacy to demonstrate how it was monitoring the safety and quality of its service.

A sample of ten prescriptions selected at random that had been prescribed and supplied by the pharmacy were checked. There were no associated consultation records found for these prescriptions. Following the inspection, the SI sent through examples of consultation records that had been made when prescribing for other people. These records had been entered as free text and did not always include a full patient history, allergy status, any checking for 'red-flag' symptoms, or appropriate safety netting. It was documented that evidence had been requested that a person was already taking a medicine regularly, but a copy of this evidence was not retained for the pharmacy's own records. Evidence about blood tests results was not routinely collected, and instead the pharmacy took the information at face-value from the person requesting the medication. Following the inspection, the SI clarified that blood test results were always requested when necessary depending on the medicine prescribed, but often the person did not have this information with them.

There was a range of standard operating procedures (SOPs) for the other services provided by the pharmacy. These were in date, and the trainee dispenser (who was not present during the inspection) had signed to indicate she had read them. Team members' roles and responsibilities were detailed in the SOPs.

The SI could explain how she would record any near misses, where a dispensing mistake was made but it was identified before the medicine had been handed to a person. She was not aware of any near misses that had occurred since she had started working at the pharmacy. She could also explain how she would record dispensing errors, where a dispensing mistake was made and the medicine was handed to a person but was not aware of any recent ones.

There were two team members present who were not involved in the sale or supply of medicines. When asked, they were clear about what they could and could not do if the pharmacist had not turned up in the morning and said that they would keep the pharmacy closed. The pharmacy had a complaint procedure, but the SI said that there had been no recent complaints. There was a current certificate of indemnity insurance displayed in the dispensary.

The right responsible pharmacist (RP) record was displayed, and the RP records had largely been filled in correctly. Controlled drug (CD) registers seen mostly complied with requirements, but some headings had not been filled in. This was discussed with the SI. The CD running balances were audited regularly. Checks of two CDs selected at random showed that the physical balance matched the recorded quantity in the balance. Records of private prescriptions dispensed largely contained the required information, but many were missing the prescriber's details. Emergency supplies were rarely made, but the two examples seen did not clearly indicate the nature of the emergency.

No confidential information was visible from the public area, and staff had signed the confidentiality SOP. A shredder was used to dispose of confidential waste. The SI confirmed she had completed safeguarding training and could describe what she would do if she had any concerns about a vulnerable people. She said that the trainee dispenser had also completed safeguarding training. She was unsure if the staff not involved in pharmacy services but working in the store had done any formal safeguarding training but said that she would check. When asked, these staff said that they would refer any safeguarding concerns to the pharmacist. Following the inspection, the SI confirmed that staff working

in the store would be completing safeguarding training as part of the pharmacy's improvement plan,

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services, and they do the right training for their roles. They feel comfortable about making suggestions or raising concerns. And they can take professional decisions to help keep people safe.

Inspector's evidence

At the time of the inspection, there was the SI (who was also a pharmacist independent prescriber), and two members of staff who worked in the beauty section. These two members of staff said that they were not involved in the sale or supply of medicines. The pharmacy also had a trainee dispenser who was not present at the inspection. The pharmacy was up to date with its workload. Team members felt comfortable about making suggestions or raising concerns, and the SI often worked in the pharmacy and was easily accessible. Team members were not set any targets for the services they provided. The SI felt fully able to take professional decisions.

The SI confirmed that she had completed training about dermatology, minor ailments, and aesthetics. She said she was currently undertaking a course in Advanced Practice for Minor Illness with a reputable provider, and provided evidence demonstrating an understanding of antimicrobial stewardship. She was aware of the requirements for Continuing Professional Development and said that she did ongoing training on medical aesthetics and was undertaking a level seven diploma. The SI said that the second PIP (who was not present) had a scope of practice in minor ailments but evidence to support this was unavailable. However, the second PIP had not initiated any prescriptions for minor ailments whilst working at the pharmacy. And instead continued the prescribing of medication for a number of conditions where the person was able to demonstrate that they were already prescribed this medication on a continued basis from their original clinician. But as discussed under Principle 1, the person's original clinician was not routinely informed. And the pharmacy could not demonstrate that it had appropriately considered the risks of this.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services and they are kept secure. People can have a conversation with a team member in a private area.

Inspector's evidence

The premises were clean and bright, and projected a professional appearance. The dispensary was located to the rear of the pharmacy. There was a consultation room available which allowed a conversation at a normal level of volume to take place inside and not be overheard. The premises were secure from unauthorised access. There was no sink in the dispensary, but the SI explained how purified water was used if a liquid medicine needed to be reconstituted, and there was also a sink available in the consultation room. She said that in practice, the pharmacy very rarely needed to reconstitute any medicines.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the pharmacy's services. And on the whole, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable sources and largely stores them properly. Staff take the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

There was a small step to enter the pharmacy through a manual door. Team members explained how they went out to assist any people who needed help accessing the pharmacy and said that the pharmacy was in the process of getting a ramp. There was enough space in the pharmacy for people with wheelchairs or pushchairs to manoeuvre. Team members were seen signposting people to the pharmacy counter if they asked for pharmacy services. People could book appointments by phoning the pharmacy.

The SI described how she undertook all her prescribing consultations face to face with the person requesting the service. The pharmacy mainly offered this service to people visiting the country from abroad who required medication during their stay and wished to have UK-sourced medicines. The pharmacy dispensed prescriptions written by external prescribers or its own in-house prescribers. External prescribers included those working at dermatology clinics. From the records seen, the pharmacy did not prescribe medicines more than once to people with conditions which required ongoing monitoring.

The SI was able to give examples of conditions she had not been comfortable about prescribing for, which included some medicines used for mental health. She said that she did not prescribe any CDs, including benzodiazepines, pregabalin, and 'z-drugs'. The pharmacy did not keep any records of when people had been refused a prescription. But the She explained that when she received a prescription from a prescriber she was not familiar with, she undertook checks such as looking at the GMC register and current guidelines. There was not a written policy for this process, and the SI said that the pharmacy usually received an increasing number of external prescriptions from the same local prescribers.

The SI explained that the pharmacy rarely dispensed prescriptions for higher-risk medicines, but could describe the additional counselling information she would provide with them. She was aware of the additional guidance about pregnancy prevention for people taking valproate medicines.

The pharmacy obtained its medicines from licensed wholesale dealers and stored them in an orderly way in the dispensary. Stock was regularly date checked, and this activity was recorded. A random selection of medicines was checked and none were found to be out of date. No Schedule 4 CDs were found on the shelves in the dispensary. The dispensary fridge showed a maximum temperature outside the appropriate range, but the current temperature was within the range. The SI explained that she was waiting for an engineer to come out and check the fridge and thought the higher temperature may be due to the ventilation at the back of the fridge. She said that the temperature had increased only recently, and the previous records of temperature seen were within the required range. Medicines for destruction were separated from stock into designated bins and sacks.

The pharmacy received drug alerts and recalls via email, and the SI could describe she action the pharmacy took in response. A record was kept of the emails received, but only for those which the pharmacy had affected stock. So, it could be harder for the pharmacy to show what it had done in response if it didn't have any affected stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. It uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy had a calibrated blood pressure meter, which the SI said she sometimes used in her consultations. There were clean glass calibrated measures for use with liquids. Computers were password protected, and the phone was cordless so could be moved to a more private area if needed. People using the pharmacy could not see the computer terminal screens.

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.