General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prince Pharmacy, 99 Edgware Road, LONDON, W2 2HX

Pharmacy reference: 1112006

Type of pharmacy: Community

Date of inspection: 15/06/2021

Pharmacy context

This is an independent retail pharmacy located on a busy main road in central London, close to Marble Arch. It is open extended hours seven days a week. The pharmacy does not offer any NHS funded services. It sells over the counter medicines, and a range of wellbeing and beauty products. It dispenses private prescriptions and it has a pharmacist prescribing service. The pharmacy also works in partnership with a private doctor who offers a telephone consultation service and this service can be accessed via the pharmacy's website. Traditionally, the pharmacy has many Arabic speaking customers, and a large proportion of people who visit the pharmacy are from overseas or visiting the area. The inspection was undertaken during the Covid-19 pandemic and the pharmacy provides covid testing services.

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 effectively identify and manage the risks associated with its prescribing services. It does not complete appropriate checks when working in partnership with other healthcare professionals to make sure they are registered with the appropriate regulators and are meeting the relevant national regulatory standards and requirements. And it does not audit or monitor its prescribing services to make sure they are safe and in keeping with current guidelines.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website does not provide enough information about the pharmacy and its services, so people are not supported to make informed decisions when accessing the services
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacist and private doctor issue prescriptions with only a limited knowledge a person's health, and they do not share information with a person's regular doctor to support their ongoing treatment. This means people might not always receive the most appropriate level of care.
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 effectively identify and manage the risks associated with its prescribing services. It does not complete appropriate checks when working in partnership with other healthcare professionals to make sure they are registered with the appropriate regulators and are meeting the relevant national regulatory standards and requirements. And it does not audit or monitor its prescribing services to make sure they are safe and in keeping with current guidelines. The pharmacy has the records that are required by law, but some records are not accurately maintained, so they do not necessarily provide a clear representation of what has happened. The pharmacy's team members understand how to keep people's private information safe and they have a basic understanding of their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) explaining how everyday tasks should be completed. A few SOPs had information missing, such as relevant contact details. Additional SOPs had been developed more recently to cover new services such as covid testing. Some team members had signed the SOPs to show they had read and agreed them, but others had not, so they might not always fully understand their roles and responsibilities. The trainee dispenser correctly explained what activities could and couldn't be undertaken if the pharmacist was absent.

The pharmacy worked with a doctor who was registered with the General Medical Council and offered a consultation service to the pharmacy's customers. The superintendent pharmacist was a pharmacist independent prescriber and he also offered a consultation service. Consultations were usually held over the telephone as the pharmacy was not currently offering face- to-face consultations. The superintendent stated that he had a constant dialogue with the doctor to ensure continuity of treatment in case there were occasions when they were treating the same person, But the pharmacy did not have a clinical management system to properly coordinate their prescribing services. There was an SOP for the pharmacist prescribing service and a prescribing framework was available. The framework referenced some out of date sources and there was no indication whether it had been reviewed to make sure it followed current best practice guidance. There was no evidence of risk assessments being completed, or audits being conducted to monitor the safety of the prescribing services. The superintendent could not confirm if the private doctor's service was registered with the Care Quality Commission as he had not checked this, so it was unclear how this service was regulated or what insurance arrangements were in place covering this activity. Professional indemnity insurance for the pharmacy was with the National Pharmacy Association and this covered pharmacist prescribing activity.

A notice confirming the pharmacy had completed a covid risk assessment was displayed. The pharmacy was spacious which meant social distancing was generally possible. Infection control measures were in place including a screen and hand sanitiser at the counter. Team members wore face mask when covering the counter but not necessarily when working elsewhere. The two team members present during the inspection had not been vaccinated and they were not routinely completing lateral flow tests to check the were infection free.

The pharmacy did not have any records of dispensing incidents. The pharmacist had only worked at the pharmacy for a short time and was not aware of any recent errors. Errors were less likely as the volume of dispensing was low, and so the team was not working under pressure. Dispensing labels were signed by the pharmacist responsible for supply as part of the accuracy check. There was a near miss template, but it did not contain any recent entries. The pharmacy's complaints procedure was outlined in the SOPs. But it was not promoted in the pharmacy or on the website, so people might be discouraged from raising a concern. The pharmacy did not use any other mechanisms to actively seek feedback about the pharmacy's services, so it might miss opportunities to make improvements.

The responsible pharmacist (RP) log was appropriately maintained. Pharmacists worked long days but there were very few recorded absences. A notice was displayed with the RP's details. Prescription supplies were recorded using a recognised patient medication record (PMR) and labelling system. Private prescriptions were retained and filed and stored at the pharmacy. Private prescription records were captured on the PMR system. A small sample of those checked did not have accurate patient and prescriber details as required by law. Prescriptions supplies made at the request of a doctor following a telephone consultation were supplied in advance of a signed prescription being received. These were recorded as private prescription supplies. The pharmacy did not keep a log of these telephone calls, so records were misleading which could make it more difficult for the team to explain what has happened in the event of a query, and the lack of documented communication between the prescriber and the pharmacist could introduce risks to the dispensing process. The pharmacist confirmed they did not supply any schedule 2 or 3 controlled drugs (CD) and the pharmacy did not have a CD register. Unlicensed medicines were rarely supplied on prescription. There were a couple of invoices for non-UK licensed medicines obtained from a specials supplier, but there were no records indicating the pharmacy had supplied these. The pharmacist felt they may have obtained these medicines for one of their other pharmacies. Records relating to the pharmacist prescriber and doctor consultations were not available in the pharmacy, so the pharmacist did not have access to them. The superintendent provided two examples of his own consultation notes which were paper based. The content was limited and did not cover some key aspects including what was prescribed and the quantity. For example, a supply of oral contraceptive did not specify the patient's smoking status which could make them higher risk.

Team members had been briefed on the principles of data protection and confidentiality and they were required to sign a confidentiality agreement. The PMR system was password protected, and confidential material was stored appropriately out of public view. Confidential paper waste was shredded. The superintendent confirmed the pharmacy was registered with the Information Commissioner's Office. A privacy notice was not displayed in the pharmacy and the notice on the website was incomplete. So people using the pharmacy may not know how this information is handled. A form was used to capture people's signed consent when they accessed the prescribing services. The superintendent subsequently provided a copy of their privacy notice.

The trainee dispenser had completed basic safeguarding training, so he was aware of the issues he might encounter and that these should be referred to the pharmacist. The pharmacist had not completed any formal safeguarding training outside of her undergraduate degree. However, she understood the principles of safeguarding and was intending to complete level 2 safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services. The team members work under the supervision of a pharmacist, and they generally receive the right training for their roles. But the pharmacy does not have formal reviews or a structured training programme, so team members may have gaps in their skills and knowledge. And the pharmacy could do more to support a culture of openness and learning.

Inspector's evidence

At the time of the inspection a provisionally registered pharmacist was working with a trainee dispenser. Footfall was minimal and the workload was easily manageable. The dispenser said the pharmacy had been much quieter during the pandemic as there were fewer tourists. Two or three other team members were employed as support staff. The pharmacist had only worked at the pharmacy for a month and the pharmacy manager was on maternity leave. Regular locums covered the pharmacist's days off. Cover was planned according to a rota. Usually two support staff worked with the pharmacist in the evening when the pharmacy was busier. The company had three other pharmacies in West London, Including one across the road. Staff from the other pharmacies could provide occasional cover if needed.

The dispenser explained he was enrolled on a Buttercups dispensing course which he was in the process of completing. Training records were not available, but the superintendent subsequently confirmed that all team members had the relevant qualifications for their role. Team members completed ad-hoc training as needed. For example, they had been trained to provide the covid testing service. But they did not have formal reviews or access to structured ongoing training programmes to make sure they kept their knowledge up to date.

There were no regular team meetings. Team members could contact the SI independently if they had a concern or query. They were not aware of a whistleblowing policy. The dispenser said he would seek advice from Buttercups if he was concerned about the practice at the pharmacy. Team members were not directly incentivised to provide services.

The superintendent was a company director. He was qualified as a pharmacist independent prescriber and he occasionally worked at the pharmacy as the RP. The GMC registered doctor did not work specific hours at the pharmacy. Team members confirmed that he visited occasionally, and he was contactable by telephone. The company's accounts and administrative staff usually worked from the office in the basement.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy provides a safe, secure and professional environment for the provision of healthcare services. It has suitable facilities, so people are able to have a conversation in private. But the pharmacy's website does not provide enough information about the pharmacy and its services, so people are not supported to make informed decisions when accessing the services.

Inspector's evidence

The pharmacy was situated in a standard retail unit. There was a spacious retail area, a medicines counter and a small open plan dispensary to the rear. The dispensary had around two metres of bench space and open shelving. The size and layout were suitable for the volume of dispensing and the amount of stock held. Fixtures and fittings were suitably maintained. Lighting was adequate and air conditioning regulated the room temperature. The pharmacy was well presented, and work areas were clean and clear. The superintendent's office behind the dispensary was also used as a consultation room. It was spacious and equipped with a desk and seating, and screened area with an examinations couch. A staff toilet with handwashing facilities were available on the ground floor next the office. Stairs from the retail area led to a basement which was mainly used as an open plan office.

The pharmacy's website www.princepharmacy.com did not contain the pharmacy's GPhC registration number or the superintendent's details. It promoted the pharmacy's 'Private doctor consultation' service but it did not explain what this entailed or provide the prescribers' details such as their registration number or information about how to check their registration. The absence of information did not support people to make informed decisions when opting to access the pharmacy's services.

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

Summary findings

The pharmacy's services are easily accessible and it sources and manages medicines appropriately. But the prescribers issue prescriptions with only a limited knowledge a person's health. And they do not share information with a person's regular doctor to support their ongoing treatment. This means people might not always receive the most appropriate level of care.

Inspector's evidence

The pharmacy was usually open from 10am until 8pm Monday to Sunday. Opening hours were flexible and hours had been reduced during the pandemic. The pharmacy had step free access from the street. The consultation room was accessible to people with mobility difficulties or wheelchair users. Some team members were able to converse in Arabic which was helpful given that many of the people visiting the pharmacy were Arabic speaking. Staff could signpost to other services such as NHS pharmacies and a nearby walk-in centre.

A small range of wellbeing and beauty products could be purchased via the website. The staff believed website orders were dispatched for another location. Covid tests could be booked via the website and 'private doctor consultations' could be accessed via a telephone link directly from the website.

The pharmacy supplied around 150 private prescriptions each month. The majority were issued by the superintendent and the pharmacy's private doctor. The address on both prescribers' prescriptions was the same as the company's pharmacy in Knightsbridge. Others were walk-in prescriptions issued by other local private clinics or hospitals. People visiting the pharmacy who requested prescription medicines were referred to either the superintendent or the private doctor; they were not aware if either of the prescribers had a specific scope of practice, so it was usually dependent on who was available. Consultations were usually conducted over the telephone. People were required to complete and sign a consent form when accessing the prescribing services. This form included some basic medical questions. Most people accessing the prescribing service were overseas visitors with hotel addresses and the pharmacy did not routinely request to see any proof of identity. The superintendent described people who requested a consultation as 'health tourists' who were under the care of a doctor in their own country.

The prescribers usually authorises the pharmacy it to make a prescription supply over the telephone, and the original prescription was provided within one or two days. A lot of the prescribing stated "as directed" which made it more difficult for the pharmacist to provide appropriate advice at the counselling stage. Prescriptions were for medicines used to treat a range of conditions, both chronic and acute, including antibiotics and some high-risk medicines. Several prescriptions included schedule 4 and 5 CDs which are known to be misused and can cause addiction. One patient had been prescribed regular supplies of dihydrocodeine and there were some examples of unusual combinations of high-risk medicines being prescribed together, for example diazepam and zolpidem. This was potentially outside of the scope of GMC prescribing guidance as the prescribers did not have access to people's medical records to make sure their use was appropriate, and there was a possibility that people could also be obtaining these medicines from other sources. Some prescriptions were issued for people diagnosed with long term conditions such as blood pressure or diabetes which require ongoing monitoring, but

the prescribers did not contact or inform a person's regular doctor to check they were being monitored and their use of medication was being reviewed. Prescribing of antibiotics did not appear to always follow antibiotic guardian guidance. Pharmacist interventions were uncommon, and no recent examples could be provided. The pharmacist indicated she used the notes section on the PMR, but she hadn't made any interventions since working at the pharmacy.

The pharmacy was listed on the government website as a private provider of general covid-19 testing. The pharmacy facilitated self-administered sampling. People usually booked a covid test via the website or they could request one at the pharmacy. People were required to provide passport details or photo ID when presenting for a test. Tests were conducted in the consultation room. The covid-19 PCR testing service was operated in partnership with an accredited laboratory who collected tests and issued results usually on the same day. The pharmacy also offered covid antigen tests for some travellers to countries where this was an entry requirement.

The pharmacist usually assembled and checked all prescription medicines. Dispensed medicines were appropriately labelled, and patient leaflets were supplied. The pharmacist understood the risks of taking valproate during pregnancy and that people should be counselled accordingly.

The trainee dispenser worked between the counter and dispensary. Pharmacy (P) medicines were stored behind the counter He understood the P medicine sales should be supervised by the pharmacist. When asked about high-risk medicines, he explained he referred all requests for codeine linctus to the pharmacist as they often got asked for this and he knew it could be misused. The pharmacist stated that she rarely sold it and often refused requests. She knew it could be abused in combination with Phenergan products and said she did not sell these together.

Medicines were sourced from licensed wholesalers and a sample of invoices were viewed. The pharmacy's stock holding was fairly low, and medicines were stored in an orderly manner. The pharmacy did not have a stock control system and stock audits were not routinely undertaken. A random check of the shelves found no expired items. Short dated items were highlighted using stickers. A date checking matrix was used to document checks. Cold chain medicines were stored appropriately, and fridge temperatures were monitored. Obsolete medicines were segregated in designated bins. These were stored in an unused toilet in the basement. There were several full bins. These had accumulated as they were consolidating the waste from the other pharmacies before arranging a collection by a pharmaceutical waste contractor. Clinical waste was disposed of in a yellow bin in the consultation room.

The pharmacist received MHRA medicine and device alerts to her personal email and the SI would often sometimes forward them. The pharmacy was also subscribed to receive MHRA email alerts, but a recent alert in the pharmacy's inbox had not been opened, and there was not audit trail showing that alerts were received and actioned. The pharmacist agreed make sure these were actioned promptly and set up a folder so they could demonstrate this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services safely. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects privacy.

Inspector's evidence

The team could access the internet and suitable reference sources such as the British National Formularies. The computer terminal was suitably located so it was not visible to the public. Telephone calls could be taken out of earshot of the counter if needed. A small medical fridge was used for storing medicines. There was a dispensary sink and a glass measure was available for preparing medicines. Counting triangles were not used; the pharmacist said most medicines were supplied in original packs. The team had access to personal protective equipment including face masks, hand sanitiser and gloves.

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.