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: 08/08/2022

Pharmacy context

This retail pharmacy is situated on a busy road near Marble Arch. The area is a popular shopping and restaurant destination frequented by tourists and London's Arabic speaking community. The pharmacy trades extended hours late into the evening over seven days a week. It dispenses a few private prescriptions, and it sells a range of health and beauty products including over the counter medicines. It also offers private consultations with a pharmacist independent prescriber. The pharmacy does not provide any NHS funded 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's risk assessments are incomplete. It does not identify all of the therapeutic areas covered by the prescribing service, the classes of medication included, or the key risks involved and a plan explaining how these risks are mitigated.
		1.2	Standard not met	The pharmacy team does not routinely assess the safety and quality of its prescribing service. And the pharmacy does not hold consultation records for its prescribing service which means the team cannot demonstrate that prescribing decisions are appropriate.
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 have appropriate safeguards in place to prescribe some higher risk categories of medicines, such as controlled drugs.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy cannot demonstrate how it monitors and mitigates all of the risks associated with its prescribing service to show it is consistently safe. And it cannot provide comprehensive clinical records relating to this service. The pharmacy suitably manages the risks associated with its retail and dispensing services safely and it has written instructions, so pharmacy team members know how to complete daily tasks. The pharmacy protects people's private information, and it generally keeps the records it needs to by law, but it needs to formalise records relating to supplies of unlicensed medicines.

Inspector's evidence

The pharmacy was one of four pharmacies owned by the same body corporate. The superintendent (SI) pharmacist was a company director and he was the main pharmacist independent prescriber offering the private consultation service. He worked across all four pharmacies and was present during the inspection. The pharmacy was generally quiet with a low footfall. The SI explained the business had been impacted by covid and it was still relatively quiet.

The pharmacy had offered Covid PCR tests at the height of the pandemic but demand for these had fallen, and the pharmacy was no longer providing this service, although it still sold Covid lateral flow tests to use at home. The pharmacy mainly sold health and beauty products including some over the counter medicines. A few nutritional supplements and beauty products were available to purchase via the pharmacy's website www.princepharmacy.com. The pharmacy dispensed a small number of private prescriptions each day. The vast majority of these prescriptions were issued by the SI in his capacity as an independent prescriber. The pharmacy had previously worked in partnership with a GMC registered doctor, but it was apparent from the private prescription records that he had not issued a prescription on behalf of the pharmacy within the last six months. The SI explained that he only issued prescriptions following a face-to-face consultation and the pharmacy was no longer offering telephone consultations as it had during the pandemic.

The pharmacy had up to date standard operating procedures (SOPs) explaining how everyday tasks should be completed. Some team members had signed the SOPs to show they had read and agreed them, but others had not. One of the pharmacists explained that the team members sometimes worked at the other Prince pharmacies, so it was likely that their SOP training records were held there.

The pharmacy had a prescribing framework, but it did not include some of the conditions that the SI prescribed medication for, such as mental health conditions or weight loss treatments. The pharmacy had a risk assessment which identified some areas of risk associated with the prescribing service in general with a plan to mitigate them. But it did not include individual risks assessments for the therapeutic areas or medications that the SI regularly prescribed identifying and showing how it mitigated the risks associated with particular medicines, for example high risk medicines such as controlled drugs (CDs) which are prone to misuse.

The pharmacy team had completed a basic audit to check the pharmacy was only working with registered healthcare professionals, but it had not completed any clinical audits of prescribing to determine whether it was safe and appropriate. The pharmacy's prescribing team had regular meetings which were documented with agenda points, but the meetings did not have minutes which means any

team members who were absent would not be able to easily obtain the information that was discussed in the meeting. People using the prescribing service were mainly from abroad so the prescriber did not usually communicate with the person's usual doctor.

The pharmacy had procedures for recording near miss and dispensing incidents, and learnings from these were discussed at monthly team meetings. The pharmacist who was responsible for each supply of prescription medicine initialled the dispensing label so they could be identified. Details of the pharmacy's ownership were displayed in the retail area with an email address so people could provide feedback or make a complaint. And the website included a complaint section with contact details.

The pharmacy had professional indemnity insurance with the National Pharmacy Association. The responsible pharmacist (RP) displayed a notice with their details and made an entry in a book to show when they were on duty as the RP. Private prescription records were recorded using the facility in the patient medication record system (PMR). The pharmacy did not stock or supply any controlled drugs (CD) which needed to be recorded in a CD register. It supplied some unlicensed medicines and certification showed it sourced these appropriately, but it did not keep 'specials' records showing an audit trail from source to supply.

The SI explained how he recorded private consultations using a clinical management system which captured details of identity checks, consent, and assessments of the patient. However, only one record from the previous day could be viewed on the system and the SI could not provide any other consultation records during the inspection. He provided a small sample of handwritten notes after the inspection showing consultation records for six patients. These records confirmed patient consent and identity was checked, and included a patient history, allergy status, details of medical assessments and examinations, and any advice provided. Evidence that the patient was on regular medication was sometimes requested and documented. Evidence for ongoing monitoring was not routinely requested and it was taken on face value from the person requesting the medication. A letter was sometimes given to the customer to hand to the primary clinician as a record of the consultation and treatment provided but they were not obligated to do so.

The pharmacy team members completed confidentiality and data protection training as part of the company's training programme. The SI confirmed the pharmacy was registered with the Information Commissioner's office. Confidential material was stored and disposed of safely. A privacy notice could be viewed on the website, but it was not displayed in the pharmacy, so people might not know how their personal information was handled.

The RP had completed safeguarding training. She explained how she would handle matters relating to vulnerable people sensitively and could signpost them or escalate a concern if needed. The SI explained he generally restricted his prescribing practice to treating adults as he did not feel he was competent in dealing with children.

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 receive the right training for their roles. The pharmacy provides some ongoing training to keep its team members' knowledge and skills up to date.

Inspector's evidence

The RP was usually supported by a single assistant working on the counter. This was sufficient to manage the workload. Several regular pharmacists covered the trading hours acting as the RP. They usually worked whole day shifts, so the working hours were long. The SI didn't usually work as the RP himself. Staff cover was planned according to a rota. Team members could work across all four pharmacies so extra staff could be requested to cover absences. The company's administrative staff worked from the office area in the basement.

The counter assistant had completed a dispensing assistant's course and a level two pharmacy apprenticeship. The company used a recognise online programme to provide ongoing training. Team members confirmed they could easily contact the superintendent for advice and support. The company's professional standards and technology leads, who were both pharmacists, were also present at the inspection. They sometimes worked as the RP at the pharmacy or in one of the other locations. The regular pharmacists had monthly team meetings when they discussed clinical matters including prescribing, complaints, and governance issues. The company had a whistleblowing policy.

The SI was qualified as an independent prescriber and had completed his initial training specialising in diabetes. He stated he expanded his scope of practice by attending a number of courses and completing assessments, and he provided a certificate showing he had completed an Advance Practice Minor Illness training course. One of the other directors was also a pharmacist independent prescriber and some of the other regular pharmacists were also completing or due to commence prescribing courses.

Principle 3 - Premises ✔ Standards 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 consultations in private. And the company website provides basic information about the pharmacy and its 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 pharmacy was spacious which meant social distancing was generally possible. Team members did not routinely wear face masks.

There was an office behind the dispensary which was also used as a consultation room. It was spacious and equipped with a desk and plenty of seating. 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 or storage space. The pharmacy's website www.princepharmacy.com contained basic information about the pharmacy and its services including the GPhC registration number and the SI's details.

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

Summary findings

The pharmacy's services are easy to access. It obtains, stores and generally supplies medicines safely. The pharmacy's prescribing service has improved some of its working practices, but it does not have sufficient safeguards in place to provide assurance that higher-risk medicines are always prescribed safely.

Inspector's evidence

The pharmacy was usually open from 10am until midnight seven days a week. 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. The consultation service was advertised via the website and people could telephone to make an appointment with the prescriber. Staff could signpost to other services available locally including NHS and private providers, and contact information was available in the dispensary.

Most of the prescriptions dispensed by the pharmacy were issued by the SI; the prescriber's address was the same as the company's pharmacy in Knightsbridge. The pharmacy also dispensed occasional walk-in prescriptions; these were mostly issued by other local private clinics or hospitals. The pharmacy had a flow chart explaining how people accessed its consultation service. People requesting prescription medicines were offered a consultation with the pharmacy's prescriber. If they decided to proceed, their ID was checked, and an appointment was arranged. People were asked to complete and sign an online consent form when accessing the prescribing service. This form included some basic medical questions and was written in English and Arabic. A large proportion of people accessing the prescribing service were overseas visitors from the Middle East region, so they often had hotel addresses and were under the main care of a doctor in their own country. A few prescriptions were issued for residents of the UK. Most prescriptions were one-off supplies which meant the prescriber did not have the opportunity to follow up or monitor the patient himself.

Prescriptions issued by the prescriber were for a wide range of conditions including cardiovascular, diabetic and asthma medications, weight loss injections, and hypnotics or anxiolytic medication. The SI explained he was not usually initiating treatment as he was usually prescribing medication that the person was already taking. He said he sometimes asked for confirmation that they were taking the medicine such as an old medication pack or documentation, and he occasionally spoke to the person's usual doctor even if they were based overseas. He did not have access to people's medical records such as their Summary Care Record. The small sample of consultation notes provided after the inspection indicated that the prescriber sometimes sought verification that the medication was already being prescribed but this was not evident on every record.

Several prescriptions written by the SI were for high-risk medicines such as schedule 4 CDs including zolpidem and Xanax which are known to be misused and can cause addiction. Some prescribing of CDs was atypical, for example, bromazepam which was not licensed in the UK. And prescriptions were sometimes issued for two months' supply so more than the recommended 30 day's supply. One consultation record for a supply of bromazepam suggested the prescriber had sought verification and contacted the person's doctor in Saudi Arabia. But the prescriber did not have routine access to people's medical records to verify information and make sure their request for CD medicines was

legitimate. The pharmacy team could not clearly demonstrate prescribing of CDs was consistently safe as the pharmacy did not have any specific safeguards in place to make sure prescribing was in line with UK prescribing guidelines. And there was a possibility that people could also be obtaining these medicines from several other sources.

Other prescriptions were issued for people diagnosed with long term conditions such as blood pressure or diabetes which require ongoing monitoring. There were numerous prescriptions for Ozempic; the SI explained he often prescribed this off license for weight loss, but this was not included in the prescribing framework and there was no risk assessment associated with this aspect of the service. The pharmacy sometimes provided the person with a letter about their treatment to hand to their usual doctor, but this was not evident on every record of the sample provided and people could opt not to pass this on to their doctor. The SI stated there were many instances where he would refuse the supply of medication, but the pharmacy did not keep any records of this.

The SI did not usually dispense prescriptions that he had issued. The RP usually assembled and checked all prescription medication. Dispensed medicines were appropriately labelled, and patient leaflets were supplied. Pharmacy (P) medicines were stored behind the counter. The dispenser understood that P medicine sales should be supervised by the pharmacist. When asked about high-risk medicines, he knew about the risk of addiction with codeine containing medicines. The RP said she did not sell codeine linctus and was cautious about selling Phenergan elixir as she knew they could be abused.

Medicines were sourced from licensed wholesalers. The pharmacy had a small stock holding and medicines were stored in an orderly manner. A random check of the shelves found no expired items. Short-dated items were highlighted using stickers and the team completed regular checks. Obsolete medicines were segregated in designated bins and the SI confirmed a waste contract was held with an authorised provider. Bins were stored in an unused toilet in the basement. There were several full bins. The pharmacy received MHRA medicine and device alerts by email and the professional standards pharmacist confirmed these were actioned and filed for reference.

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 used to access the PMR 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 and the temperature was monitored to check it was suitable for the storage of medicines. There was a small dispensary sink and a measure for preparing medicines.

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.