General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Smart Pharm Ltd, Suite 18, Space House, Abbey Road, Park Royal, LONDON, NW10 7SU

Pharmacy reference: 1122566

Type of pharmacy: Internet / distance selling

Date of inspection: 26/06/2024

Pharmacy context

This pharmacy is in a business park in northwest London and closed to the general public, so it does not see people face-to-face. It dispenses NHS and private prescriptions. Medicines are delivered to people's homes or to a nearby branch of the pharmacy, from where people can collect them. It supplies medicines in multi-compartment compliance packs for people who have difficulty taking their medicines at the right time. It also dispenses some private prescriptions issued from its other pharmacy for a range of conditions and there are medicines for sale through a website https://medsrus.co.uk. The pharmacy mainly supplies medicines to people living in the United Kingsom (UK). This was a routine inspection focussing mainly on the pharmacy's association with the owner's online prescribing service, so some pharmacy services and some standards were not covered.

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 processes involved in running the pharmacy and its involvement in the online prescribing service under the current business model are not set out in the SOPs. The pharmacy's written instructions require a review to update how it identifies and manages risk. The pharmacy does not adequately assess and document the risks involved in providing its services, particularly when dispensing prescriptions issued by its owner's online prescribing service
		1.2	Standard not met	The safety and quality of the pharmacy services are not regularly reviewed and monitored. The pharmacy has not completed any recent audits to provide assurances that its services are safe, particularly when dispensing prescriptions issued by its owner's online prescribing service.
		1.8	Standard not met	The pharmacy is not adequately safeguarding vulnerable people. It does not have a specific documented safeguarding policy to guide the team on the process to follow in the event of a concern for vulnerable people associated with the online prescribing service.
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 has not written down the processes its team should follow when running the pharmacy and providing its online prescribing service. It has not reviewed or updated its written instructions so they are out of date and do not help its team members identify and manage the risks involved in completing their tasks. The pharmacy does not adequately assess the risks involved in providing its services and it does not routinely document risk assesments (RAs). The pharmacy's questionnaires are tailored for specific medical conditions but people do not have to consent to sharing information so the pharmacy does not always verify the medical information it is given before supplying medicines. And people's doctors may be unaware of treatments they obtain elsewhere. The pharmacy generally keeps the records it is required to keep. Consultation records do not always include information on counselling provided or details of refusals to supply medicines. The pharmacy does not have a specific documented safeguarding policy to guide the team and protect the welfare of vulnerable people associated with the online prescribing service. A safeguarding SOP does not set out what to do if the pharmacy team have a concern about the safety of a child or vulnerable person.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) at the pharmacy worked alone and explained that the pharmacy computer flagged up picking errors and highlighted short-dated medicines. The RP viewed the prescriptions on the pharmacy computer screen, checked the patient records, picked medicines and scanned the barcodes on their manufacturer's packaging. The computer highlighted any medicines which did not match what was on the prescription. The RP used baskets to separate medicines and labels for each person and did take mental breaks where possible when dispensing. The pharmacy gained people's consent for taking in their prescriptions and dispensing them. The RP completed a legal check to make sure all the required fields were completed. And clinically checked interactions between medicines prescribed for the same person. The RP printed their repeat prescription, attaching the dispensing label and contacted the prescriber. The RP kept emails of the interventions but did not always attach them to the patient medication record (PMR). The RP highlighted prescriptions containing high-risk medicines and keeping a record or audit trail of interventions was discussed.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had a review date in February 2023. The standard operating procedures (SOPs) did not cover the working business model between both pharmacies owned by the same company. There were no SOPs specific to dispensing private prescriptions issued from the other pharmacy's prescribing service. Nor were there any documented risk assessments (RAs). The RP explained that prescriptions for MedsRus were processed at this pharmacy or the other pharmacy (9011292) owned by the same company. The other pharmacy was used as a collection point but the processes describing how both pharmacies interacted with each other to provide services were not set out in the SOPs.

There was a tote box on the floor of the pharmacy which contained bagged prescription medicines such as compliance packs. The transfer of medicines SOP was not seen and there was no audit trail for medicines being transferred from this pharmacy to the other pharmacy. But the RP explained the

procedure and the audit trail indicating safe and effective delivery of prescriptions from this pharmacy to people's homes or the other pharmacy for collection. The delivery record sheets were retained at the other pharmacy.

The pharmacy had a phone number so people could contact the RP. The company's website displayed an email address, telephone number and details of how and where to contact the customer service team. It detailed Terms and Conditions which included the complaints procedure, returns and privacy notice. And the pharmacy had arrangements to make sure confidential information was stored and disposed of securely.

The pharmacy dispensed NHS prescriptions and private prescriptions which were issued by the superintendent pharmacist (SI) who was an independent prescriber (IP) and the sole prescriber for this service based at the other branch of the pharmacy. The SI stated that he had started dispensing medicines for this prescribing service in the past few months. The website offered treatments for chronic health, general health, men's health, sexual health, travel, wellbeing and women's health. The pharmacy's questionnaires were tailored for specific medical conditions but people could choose not to consent to sharing information so the pharmacy did not always verify the medical information it was given before supplying medicines. And there was a risk people's doctors may be unaware of treatments they obtained elsewhere. Consultation records did not always include information on counselling provided or details of refusals to supply medicines.

The pharmacy business continuity plan was retained in the SOP folder. The pharmacy generally did not participate in audits to monitor the safety and quality of the online service such as audits of the delivery service or clinical audits. But the responsible pharmacist (RP) was aware of the new rules for dispensing valproates so people would receive them in the original packaging.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register and CDs were audited regularly to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies it made of private prescriptions but the prescriber details were not correctly recorded.

The pharmacy was registered with the Information Commissioner's Office (ICO) and the privacy notice was on the website. It disposed of confidential wastepaper securely. The RP was aware of her role in protecting patient confidentiality. The pharmacy computer system was password protected and not visible to unauthorised people. The SI had completed level 2 safeguarding training and described safeguarding scenarios in relation to refusing treatments for people under 18 years old. The SI verified people's age by asking for identification documents when he felt this was necessary. The RP was signposted to the NHS safeguarding App. A safeguarding SOP set out what to do if the pharmacy team had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The responsible pharmacist (RP) satisfactorily manages the daily workload in the pharmacy. The RP and SI complete training to keep-up-to date and support how they provide their services.

Inspector's evidence

On the day of the visit, the RP was working alone at the pharmacy.
The RP completed study topics relevant to her position via Centre for Postgraduate Pharmacy Education (CPPE) as ongoing continuing professional development. There were no formal appraisals but the RP had regular contact with the SI, and felt able to provide feedback and was aware of the whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is light, bright and of sufficient size for the current workload. It protects its medicines stock and people's private information when it is closed outside its hours of business.

Inspector's evidence

The registered pharmacy was in an office unit. It was air-conditioned, bright and clean. The pharmacy was only accessible to authorised personnel. The pharmacy's premises were not open to the public face-to-face, but people could contact the pharmacist by phone or email. The pharmacy was not very large and some of the floor area was not clear. There was a desk, workbench and storage space to accommodate its current workload. There were shared staff facilities the RP could use when needed.

The dispensary workspace and storage were maximised by keeping it tidy. Worksurfaces in the dispensary were clean. The pharmacy's online prescribing service (https://medsrus.co.uk/) initially had inaccurate information as it stated it was a registered pharmacy with the GPhC registration number of this pharmacy (1122566) given. The GPhC's voluntary logo also took people to the details of this pharmacy. The website did not prominently display details of the prescriber. The website information was amended to show the details of the other pharmacy where the prescribing service is based.

The website displayed customer service details at the address of the pharmacy in the business park, info@medsrus.co.uk and a phone number. But elsewhere on the website, the details given were sales@medsrus.co.uk with the same phone number but the address of the other pharmacy. This may be misleading to people who wanted to access this pharmacy and its services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is closed to people but they contact it via the phone or email. It gets its medicines from reputable sources and it stores them appropriately and securely. The pharmacy delivers medicines to people in their homes or to the other pharmacy's premises for people to collect. It makes sure people can access the website twenty-four hours per day. It supplies medicines to people in the UK who use the online prescribing service via a courier with tracking facilities. And in packaging which helps to keep it medicines at the correct remperature. The pharmacy makes sure people have the information to use their medicines safely, But it doesn't have an adequate system to notify the MHRA about concerns about medicines and for locums to refer to alerts about medicines.

Inspector's evidence

People mainly accessed the pharmacy and its services via the phone or email. The dispensing labels showed the 'medsRus' name, along with the pharmacy's address, phone number and website details so people could contact the pharmacy. The online prescribing service was available to people to access twenty-four hours a day, Both services were manned on weekdays from 9am to 5pm. The pharmacy received prescriptions from the online prescribing service electronically. The SI described the systems being used as secure and encrypted.

The pharmacy dispensed NHS prescriptions as this was the nominated pharmacy for some people and some private prescriptions issued by the SI through the online prescribing service. The dispensing labels being used at the point of inspection listed the address and contact details.

Some prescriptions were delivered to people's homes and some were transferred to the other branch of the pharmacy which acted as a collection point. The pharmacy delivered medicines to people in the UK who used the online prescribing service, through a courier service (Royal Mail). This service had tracking facilities. To help keep medicines that required refrigeration cool during the delivery process, ice packs were used. The SI had assessed the reliability of the ice packs. For failed courier deliveries, three attempts were made before the medicine(s) was sent back to the pharmacy so no medicines were left unattended. The pharmacy signposted people to their local pharmacy if they required disposal of medicines which had been delivered.

The RP made up people's prescriptions and kept the dispensary and workbench tidy. The RP referred to the prescription when picking and labelling medicines. She did not always initial each dispensing labels because of working alone. Patient information leaflets were routinely supplied with dispensed medicines. And assembled prescriptions were all checked by the RP before they were dispatched. The RP was aware of updated rules for dispensing valproate-containing medicines in the manufacturer's original full pack. And there were valproate information leaflets to give to people.

The pharmacy supplied medicines in multi-compartment compliance packs to help people take their medicines at the right time. The pharmacy re-ordered prescriptions for people and checked them for changes in medicines since the previous time. The RP provided a brief description of each medicine

contained in the compliance packs and patient information leaflets (PILs) with each set of packs to help ensure people had the information they needed to take their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via NHS email showing changes in treatment. The RP sent dispensed medicines and compliance packs to the nearby branch for collection. Some were delivered to people's homes. High-risk medicines such as antibiotic suspensions were not re-constituted with water until they were about to be delivered or handed out to the patient or their representative.

The RP explained the delivery procedure and the audit trail indicating safe and effective delivery of prescriptions from this pharmacy to people's homes or the other pharmacy. The delivery record sheets were retained at the other pharmacy.The pharmacy used recognised wholesalers to obtain its pharmaceutical stock which was arranged tidily on the shelves in the original manufacturer's packaging. The RP checked the expiry dates of medicines but a small number of date-expired medicines were found and removed from the stock. And checking the expiry date as part of the final check when dispensing them was discussed. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. CDs were generally stored in line with safe custody requirements. There were several cases of pharmaceutical waste medicines which required removal.

The pharmacists received alerts and recalls about medicines issued by the Medicines and Healthcare products Regulatory Agency (MHRA) on their own phones. So the alert may not be available to a locum pharmacist and there was no system for notifying the MHRA if there were concerns about the medicines it supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date reference sources. It needed very little equipment for the services it provided. It had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And the pharmacist regularly checked and recorded the maximum and minimum temperatures of each refrigerator on the days the pharmacy was open to make sure fridge items were stored at the correct temperature. The pharmacy's computers and PMR system were password protected. And access to them and the company's other computer systems was restricted to authorised team members. And it collected confidential wastepaper for secure disposal.

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.