General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pro Chemist, Unit 5 Central Business Centre, Great Central Way, London, NW10 0UR

Pharmacy reference: 9011162

Type of pharmacy: Internet / distance selling

Date of inspection: 02/03/2022

Pharmacy context

The pharmacy is in a business park in north west London. It is not open for people to visit in person as it provides its services at a distance. The pharmacy dispenses NHS and private prescriptions and provides health advice. It mainly provides services to care and nursing homes. It supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. The pharmacy sells some over-the-counter medicines through its website. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	N/A	N/A	N/A
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 met

Summary findings

The pharmacy's working practices are mostly safe and effective. It has clearly written instructions which tell team members how to manage risks and complete tasks in the right way. And it continually monitors its services to protect people's safety. Pharmacy team members learn from mistakes they make to help prevent similar mistakes in future. They have introduced ways of working to help protect people and minimise the risk of COVID-19 infection. The pharmacy keeps all the records it needs to by law so it can show it is providing its services safely. And it enables people to give their views on how it can improve its services. Members of the pharmacy team understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The pharmacy team recorded near misses or mistakes on PharmSmart on the pharmacy computer and produced a monthly patient safety report. It included actions taken to avoid the same mistakes occurring in future. Locum staff could log in and record near misses via a QR code. The superintendent pharmacist (SI) shared the learning outcomes from these mistakes with members of the pharmacy team to learn from them so they did not happen again. The RP explained that medicines involved in incidents, or were similar in some way, were generally separated from each other in the dispensary. The SI recorded complaints on PharmSmart and incidents were reported to the NHS 'learning from patient safety events' (LFPSE) service.

The pharmacy team checked Electronic Prescription Service (EPS) prescriptions for changes in medication from the previous issue. They contacted the prescriber or the care or nursing home staff if they needed to and the email replies were retained as an audit trail. Members of the pharmacy team responsible for making up people's prescriptions into compliance aids used baskets to separate each person's medication. If one person picked medicines then a different person placed them into the appropriate slots in the compliance aid. So they could spot each other's mistakes. The dispensing assistants kept their workbench tidy. The pharmacy had a back-up printer to deal with the workload if the main printer failed to function. Assembled prescriptions were not packed for delivery until they were checked by the pharmacist. The SI had designed a care home checklist to be completed for each care or nursing home supply cycle which included patient and medication details, dispensing audit trail and delivery date. Upon completion, the checklists were filed and retained as an audit trail when dealing with future queries.

The pharmacy had recently reviewed standard operating procedures (SOPs) for most of the services it provided. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. Their roles and responsibilities were described within the SOPs. A team member explained that they wouldn't hand over prescription medicines to the delivery driver if a pharmacist wasn't present. The SI had reproduced the most frequently used SOPs into bullet points in large print for quicker reference by the pharmacy and locum team members. But team members could still refer to the more detailed version of the SOP. The

pharmacy had a complaints procedure and obtained feedback during a monthly call to the homes who used its services. The pharmacy sold some over-the-counter medicines following a sales protocol through its website. People had to complete a questionnaire and a medicine was only supplied if appropriate. The SI monitored sales and could search computer records to investigate or refuse a sale if the pharmacy received inappropriate requests for medicines liable to abuse, misuse or overuse. Medicine stock was stored on shelving around the dispensing bench with fast moving medicines in baskets.

The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. The SI had liaised with other community pharmacies who could provide services on behalf of this pharmacy in case problems arose from the pandemic. During the earlier time in the pandemic, the pharmacy team had worked in shifts so the workload was covered but it reduced the number of people in contact with each other in the workplace. The SI had completed a written occupational COVID-19 risk assessment for each team member and was aware that any work-related infections needed to be reported to the appropriate authority. Members of the team were self-testing for COVID-19 twice weekly. They wore fluid resistant face masks and tried to observe the 'two metre rule' to help reduce the risks associated with the virus. And they washed their hands regularly and used hand sanitising gel.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was and kept a record to show which pharmacist was the RP and when. The pharmacy had an electronic controlled drug (CD) register on PharmSmart. Team members had their own log-in details and PharmSmart prompted the team when the monthly balance check of CDs was due. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. It recorded the private prescriptions it supplied electronically. And these were in order.

The pharmacy was registered with the Information Commissioner’s Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people’s personal information couldn’t be seen by other people and was disposed of securely. The pharmacy had a safeguarding procedure and the RP had completed a level 2 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. They work well together to manage the workload. And they hold meetings to share information about their work. Team members can make suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist who was RP on the day of the visit and a second full-time pharmacist, a full-time locum pharmacist, two full-time locum pharmacy technicians, two full-time dispensing assistants, one part-time dispensing assistant, a part-time locum dispensing assistant and one part-time delivery driver. Team members were enrolled on or had completed accredited training in line with their roles. Two part-time people had had in-house training to pick medicines and pack away orders. Formal training for picking and packing was discussed and the SI gave an assurance that he would check the guidance. The SI was signposted to GPhC guidance for Requirements for the education and training of pharmacy support staff (Oct 2020).

Members of the pharmacy team worked well together. So, prescriptions were processed and compliance aids were prepared safely. The SI was RP on the day of the visit and responsible for managing the pharmacy and its team. Training had been completed in line with the pharmacy quality scheme (PQS) in topics such as 'Lookalike soundalike'(LASA) medicines, risk assessment, inhaler technique, remote consultation skills, infection control, antimicrobial stewardship and health inequalities. Industry publications with training topics were also available. Most staff studied at home. The SI conducted regular appraisals for staff to highlight training needs and monitor performance. And the SI organised team meetings to discuss workflow, review dispensing mistakes and share feedback from service users.

Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They had suggested reproducing the dispensing SOP in large font bullet points for quick reference and had improved the procedure for dealing with outstanding medicines and filing the owing prescriptions. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of healthcare. It protects the privacy of people receiving services and prevents unauthorised access to its premises when it is closed. So it keeps its medicines and people's information safe. The pharmacy's team members have introduced ways to help protect them from COVID-19 infection.

Inspector's evidence

The registered pharmacy premises were in an industrial unit which was bright and secure. The pharmacy did not have direct face-to-face contact with members of the public but there was hand sanitiser and team members tried to observe the two metres rule to manage the risk of COVID-19 infection. And there was an air conditioning unit to make sure the pharmacy and its team didn't get too hot. The dispensary was spacious and laid out in separate workstations with large workbenches. For instance, a team member screened and downloaded EPS prescriptions at one bench and dispensing took place at another bench. The pharmacy stored items on shelving units but some bulk items such as flattened cardboard boxes were on the floor. The pharmacy team members were responsible for keeping the pharmacy's premises clean and tidy, on a daily basis. And a cleaner cleaned the pharmacy regularly and cleaning records were maintained. The pharmacy's website had up-to-date information such as the pharmacy details and how to contact the pharmacy. The SI monitored sales and could search computer records to investigate or refuse a sale if the pharmacy received inappropriate requests for medicines liable to abuse, misuse or overuse.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays information on its website so people with different needs can access the pharmacy's services. The pharmacy's working practices are mostly safe and effective. It obtains its medicines from reputable sources. And it stores and manages them so it can be sure they are fit for purpose. Members of the pharmacy team make sure people have all the information they need to use their medicines safely. And they know what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy did not have an automated door. And there was a slight step at its entrance. People could contact the pharmacy by phone or via the website to ask about using the pharmacy's services. Members of the pharmacy team were helpful and signposted people to another provider if a service wasn't available at the pharmacy. And the most usual service was the out-of-hours doctors. Team members spoke Spanish, Gujarati and Hindi which was helpful to people whose first language was not English. The pharmacy supplied COVID-19 rapid lateral flow tests that people could use at home. This was to help find cases in people who didn't have symptoms but were still infectious. The pharmacy team had completed training in line with the PQS and planned to conduct the anticoagulant audit. The SI was trained to provide the community pharmacist consultation service (CPCS) but the pharmacy had received very few referrals.

The pharmacy had a delivery service because people couldn't attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right place. It had a drop sheet for each home with anonymised patient details. The pharmacy had a delivery person for local deliveries. And it used couriers for other deliveries which were tracked to their destinations. Large delivery labels were printed with a space for team members to sign identifying who packed the contents and delivered the package.

The pharmacy had disposable compliance aids for people who found it difficult to manage their medication. Each compliance aid had 28 slots and a colour-coded seal which represented the time of day the medicines should be consumed during the 28-day cycle. The pharmacy printed the compliance aid seal with the patient's details and a photograph. There was a back-up printer to assist business continuity in the event of a system failure. The printed prescription, seals and any related documentation were clipped together and passed to the dispensing assistants at the dispensary bench to be dispensed. By the time the compliance aids and other items were ready for delivery to the patient or their representative, the audit trail had been completed by the person who processed and checked the prescription for printing, the person who picked the medicines, the person who placed the tablets or capsules in the compliance aid and the pharmacist who did the clinical and final checks.

The pharmacy used a computer system to manage compliance aid prescriptions. There were very few referrals from the discharge medicines service. The care and nursing homes had their own log-in details

to access the system and order the prescriptions for medicines for each patient. The pharmacy team checked EPS prescriptions against what the care home had ordered and any hospital discharge summaries to create a report of missing items. The report was sent to the prescriber and the care home to resolve any unexpected changes in medication. The EPS prescriptions, and labelling, including seals, were printed. The pharmacy team checked whether a medicine was suitable to be re-packaged. High-risk medicines, acute medicines and bulk items were usually supplied separate to the compliance aids. The pharmacy recorded these items on an electronic medicines administration record (eMAR) chart and provided patient information leaflets. So, patients and the people helping them would have the information they needed to make sure they used their medicines safely. The pharmacist provided counselling to people over the phone. The SI visited the homes on an annual basis but spoke to the care home lead person once a month. He provided training and was launching an online training programme to the home staff. Topics included medicines management and completing the eMAR charts.

Members of the pharmacy team knew which of them had prepared a prescription by the signed dispensing labels and care home checklist. They marked some prescriptions to highlight when a pharmacist needed to speak to the person or the care home staff about the medication to be delivered. The pharmacy had warning cards such as a 'catheter passport' to give to people regarding their medicines. The team members were aware of the valproate pregnancy prevention programme. Although most people they supplied were not in the at-risk group, they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. And the SI planned to re-iterate information about valproate and medicines requiring therapeutic monitoring at the next care home training event. The pharmacy's website did not offer a prescribing service but people could complete a questionnaire explaining the choice of medicine. they wanted to purchase. The pharmacy retained email website orders for monitoring inappropriate orders for medicines which were liable to abuse, misuse and overuse. The computer system flagged orders exceeding the maximum of one item allowed in the basket at check-out.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer’s packaging. And the dispensary was generally tidy. The pharmacy team checked and recorded the expiry dates of medicines every month. No expired medicines were found on the shelves amongst in-date stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, which weren’t exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines the care homes returned to it. And these medicines were kept separate from stock in pharmaceutical waste bins. The pharmacy received alerts and recalls about medicines and medical devices via PharmSmart. And the RP described the actions they took and what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had a few measures for use with liquids, and some were used only with certain liquids. The pharmacy team could access up-to-date reference sources. The pharmacy had a new refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator which were recorded. The pharmacy shredded confidential wastepaper. And restricted access to its computers and patient medication record system. So, only authorised team members could use them with their password. And its team members used their own NHS smartcards.

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.