

Registered pharmacy inspection report

Pharmacy Name: British Chemist, 381 Church Lane, London, NW9 8JB

Pharmacy reference: 9011271

Type of pharmacy: Internet / distance selling

Date of inspection: 19/05/2022

Pharmacy context

The pharmacy is in a parade of businesses in a mixed commercial and residential area. It provides some services at a distance and face to face. The pharmacy dispenses private prescriptions and provides health advice. Services listed on its website include prescribing and aesthetics. It sells some over-the-counter medicines from the pharmacy's premises and through its website. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected. The pharmacy does not dispense NHS prescriptions or provide NHS services.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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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 routinely assess or manage the risks to patient safety from its services. For instance, the SOPs do not underpin all professional services, there is a lack of prescribing policies and a mechanism to share information with the person's usual doctor, supply of high-risk medicines such as Phenergan liquid.
		1.2	Standard not met	The quality of services is not monitored. For instance there are no arrangements to learn from things that go wrong including use of audits, complaints, patient safety incidents and near misses.
		1.6	Standard not met	Records are not maintained of the consultation, treatment prescribed, follow up and clinical information which should be shared with the usual healthcare professional or doctor.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacist has limited qualifications, and has not undertaken sufficient additional training for his clinical role and some of the specialist services provided.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not display enough up-to-date and accurate information on its website. And people can select prescription only medicine prior to an appropriate consultation.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacist does not keep satisfactory records of consultations or share information with the person's usual doctor. The pharmacy does not have appropriate safeguards in place to prescribe some categories of medicines.
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 routinely assess the risks involved in managing its services. And it does not review its services to ensure they remain safe. The pharmacy has written instructions on how to complete some tasks. But, they do not underpin all services. The prescriber does not always keep records of people's relevant clinical information or share it with their doctor or with other healthcare professionals. The website does not display information about how to complain and this makes it harder to raise concerns. This could mean the pharmacy misses out on feedback it can use to improve its services. The pharmacy protects people's private information.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) prepared by the superintendent pharmacist (SI). They were last reviewed in November 2021 and included responsible pharmacist (RP) procedures and a sale of medicines protocol. Generally, the SOPs focussed on the dispensing process and did not cover prescribing for individual medications or medical conditions. The SI was a pharmacist independent prescriber (PIP) providing the online and face-to-face prescribing service as well as selling pharmacy (P) and general sales list (GSL) medicines. There was little information regarding the SI's prescribing scope of practice or PIP training and knowledge. As the SI was a sole prescriber, it was unclear how the SI would obtain peer review and oversight of his prescribing. And he was unable to provide a prescribing policy. The SOPs did not cover sharing the consultation information with the patient's regular health care professional (HCP) and doctor.

There was little guidance on the prescribing service in relation to the consultation documentation, medication choices and the formulary in use. During the visit, it was not possible to access any patient records in the consultation room or in the pharmacy's dispensary. And there was very little information about clinical audits such as an audit of the prescribing service or the clinical patient assessments. These included measuring blood pressure, body mass index, cholesterol or consideration of blood test results prior to prescribing a medication. Following the visit, the SI explained new software he had installed which would audit prescribing trends and top 10 medicines being prescribed.

The SI was prescribing for conditions such as asthma, hypertension, diabetes, long-term care management, hair loss, premature ejaculation, contraception and fertility treatments. There was no antibiotic policy and no antibiotic stewardship in place. The SI explained that when he prescribed antibiotics, he referred to The National Institute for Health and Care Excellence (NICE) clinical knowledge summaries (CKS) for antibiotic prescribing but did not use local antibiotic prescribing guidance.

The online consultations were questionnaire based. There was no written evidence of face-to-face consultations and any advice or information given to ensure people used the pharmacy's services safely. The SI did not routinely share clinical patient information with the person's usual doctor but relied upon people to share any information with other HCPs. For instance, the SI prescribed a specific brand of medicine for a patient whose doctor would not prescribe by brand. The patient had informed

his doctor that he was supplied the branded medicine by British Chemist. The SI prescribed medication for long-term conditions (LTCs) such as hypertension and diabetes. But there was no regular information transfer to the same patients' usual doctors. Any LTC monitoring was conducted by the patients' doctors but there was no communication between them and the SI, so he was unaware of any blood results or specific tests.

The pharmacy had online consultation questionnaires for some high-risk P medicines on the website such as 100ml x Phenergan 5mg/5ml liquid. The questionnaire asked for information on: age of intended user, symptoms, allergies, medical conditions and other medicines being taken. There were some printed questionnaires with a hand-written record indicating that there was refusal of the sale of some Phenergan and the occasional prescription only medicine (POM). Around 18 packing slips were seen during the visit for the dispatch of Phenergan 5mg/5ml liquid which people had ordered.

The SI explained that he contacted people's doctors sometimes although there was no evidence of this. Before transcribing medications for patients, the SI stated that he would check the patient's summary care record (SCR) or contact the patient's GP to confirm the patient was prescribed the medication. There was no evidence that was the case as the prescriber did not document patient consultations or communication with the wider primary care team. The SI transcribed medicines in conditions where he had had no formal training such as diabetes and asthma. The SI had prescribed high-risk fertility medication without any training in this area. An inhaler to treat asthma and a medicine liable to misuse, abuse or overuse had been prescribed but there was no evidence of long-term monitoring or referral back for review.

The SI stated during the visit that the pharmacy had a complaints procedure online to record patient safety incidents. But later he explained that it had not been uploaded yet. And there was no complaints mechanism for face-to-face consultations other than an NHS Patient advice and liaison services (PALS) service. This was not relevant to the pharmacy as it was not providing an NHS commissioned service. People could post their views and suggestions online on how it could do things better. There was an "Ask a Question" section on the website. Patients could ask a question by completing the online form.

Although not seen during the visit, the SI explained that he had completed risk assessments to manage the effect of COVID-19 on the premises in line with local council requirements. And he had tested regularly for COVID-19 infection. There were hand washing facilities and hand gel to apply. The SI was unable to provide any risk assessments which he had completed to identify and manage the risks involved in providing services.

The SI used baskets to separate each person's medication when he was making up people's prescriptions. He checked the registration status of the prescriber on the relevant register. For instance, a doctor's registration would be checked on the General Medical Council's register of practitioners. The SI referred to prescriptions when labelling and picking products. And then he set the assembled prescription aside, taking a mental break before checking (clinical and final) and bagging the medicines. There was very low volume dispensing and when the SI worked alone in the pharmacy, he spotted mistakes or near misses after the mental break. But he didn't routinely record his mistakes or the lessons he learnt from them. So, he could be missing opportunities to spot patterns or trends with the mistakes. The SI kept a small stock of medicines in the dispensary. If the SI had to check an interaction between two medicines for the same person, he could gain consent from the patient and access their SCR. But the outcome of interventions was recorded on post-it notes which may become detached and mislaid.

The pharmacy displayed a notice and maintained a record that told people who the RP was and when. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it

provided. At the time of the visit the pharmacy had not supplied any unlicensed medicinal products and no CDs in stock requiring records to be kept. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied. And these generally were in order. The pharmacy was registered with the Information Commissioner's Office. Displaying a notice to tell people how their personal information was gathered, used and shared by the pharmacy team was discussed. The pharmacy's computer system was password protected and backed up regularly. Confidential wastepaper was disposed of securely. The SI had completed a level 2 safeguarding training course and knew what to do or who to make aware if he had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacist is unable to demonstrate that he has satisfactorily completed all the appropriate training required to support him in providing some clinical services. The pharmacy does not provide its pharmacist with suitable opportunities for peer review to identify gaps in their pharmacist's skills and knowledge.

Inspector's evidence

The pharmacy team comprised the SI who was the full-time pharmacist and a PIP. A recently recruited part-time medicines counter assistant had not yet been enrolled on accredited training in line with the role. The SI was signposted to GPhC website to: 'In practice: Guidance for pharmacist prescribers Nov 2019' and 'Guidance for employers on the education and training requirements of pharmacy support staff October 2020'.

The SI explained that his business continuity plan would involve closing the pharmacy if necessary due to staff illness. As it would be difficult to find a locum pharmacist who could cover this model of pharmacy. And the SI may purchase another pharmacy to facilitate planned capacity increase in the turnover of the business. The SI's scope of practice was hypertension, and he had no other formal training on other long-term conditions or testimonials from peers to demonstrate understanding and competence. As the SI was a sole prescriber, there was little opportunity to obtain peer review and oversight of prescribing. There were low volumes of prescriptions, but the current staffing level meant there was little team support for prescribing and clinical checks.

There was no evidence of clinical audit for the prescribing services and no reporting system to monitor prescribing errors. So, the SI missed the opportunity to learn from monitoring of these services. The SI had no qualifications or specific training to prescribe a specialist medication which was usually prescribed by fertility clinics. But he had issued private prescriptions for one of these medicines. The SI had undertaken aesthetics training in 2017 but no updates since then. Following the visit, the SI provided some evidence of other training he had completed and this included anaphylaxis, female genital mutilation to accompany the travel vaccination and travel health services, safeguarding and bcg scar training. The SI explained that the aesthetics service was not operational, and he planned to undertake a refresher course before commencing treatments. Training to provide phlebotomy services was undertaken in July 2020. The SI had trained to administer travel vaccines via patient group direction (PGD). He had completed online yellow fever vaccination training but still had to complete the required physical attendance training.

Following the visit, the SI attended a continuing professional development event in 'Walk in Clinic in Community Pharmacy Training' which was a clinical prescribing course. The SI described Centre for Pharmacist Postgraduate Education (CPPE) modules he had completed, but the evidence was from 2011 on contraception so no longer relevant.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy does not display enough up-to-date and accurate information on its website. And it allows people to choose medication before having any consultation with the prescriber. Overall, the pharmacy's premises are clean and secure. The design and layout of the pharmacy is generally suitable for its activities and the provision of healthcare. The pharmacy prevents unauthorised access to its premises when it is closed. So, it keeps its medicines and people's information safe.

Inspector's evidence

The registered pharmacy's premises were bright, secure and generally clean and tidy. The pharmacy had been re-fitted since the previous visit. It was well lit and steps were taken to make sure the pharmacy didn't get too hot. The pharmacy had a retail area, a counter, a small dispensary and storage space. There were some items stored on the floor behind the pharmacy counter. The pharmacy had a consulting room towards the rear of the premises which protected people's privacy. But there was no method or equipment to record consultations.

The website did not comply with GPhC 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (updated March 2022)'. People could choose their prescription only medicines (POMs) before having a consultation. The website did not display all the required information about the pharmacy, the owner and the pharmacist. And information about some of the services available was not accurate. There was feedback from service users but how to raise a concern was not obvious. The SI confirmed that the online complaints procedure and how to raise concerns was still to be uploaded.

Principle 4 - Services Standards not all met

Summary findings

The pharmacist does not keep any suitable records of consultations or share information with the person's usual doctor. The pharmacy does not have appropriate safeguards in place to prescribe some categories of medicines. People with different needs can access the pharmacy and its services. And the pharmacy makes checks on identity and age of people to ensure they access services which are suitable. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages them so it can be sure they are fit for purpose. The pharmacist knows what to do if any medicines or devices need to be returned to the suppliers but it does not keep records so it may not be able to show that it took the right steps to keep people safe.

Inspector's evidence

The pharmacy didn't have an automated door. And there was a slight step at its entrance, so it was not level with the outside pavement. But the SI tried to make sure people could access the pharmacy services. There were notices at the entrance with opening hours and inviting people to ring the doorbell to access the pharmacy. And there was a ramp with anti-slip strips leading from the retail area to the back of the pharmacy's premises so people could use the consultation room. There was a signposting SOP and the SI signposted people to a nearby pharmacy if a service was not available at this pharmacy, such as COVID-19 vaccinations. The website included an 'Ask a Question' section and there was a chat function for people to use. Consultations were made online, but the majority were 'face-to-face' with the SI. People could access online or face-to-face prescribing services. For people whose first language was not English, the SI used Google Translate to assist them.

The people who accessed the website were UK and Channel Islands based. The SI checked the age and identity of people using a service by asking to see their passport or driving license. If they were not able to verify their identity or age the order was refunded. Patient consent was recorded online, and the website restricted the quantities of certain lines which could be ordered. Orders were screened for multiple ordering by checking different forms of identification and IP address. If necessary, the SI checked the purchaser's post code with the couriers who delivered goods on behalf of the pharmacy. Payments were taken online from people using Stripe Payment processing or via PayPal payment request. The SI was signposted to the Identity Verification and Authentication Standard for Digital Health and Care Services, ICO's website for guidance on consent and Payment Card Industry Data Security Standard (PCI DSS).

The SI was prescribing for clinical conditions for which he had not been trained such as diabetes, asthma and fertility. A prescription had been issued for a medicine liable to misuse. And he was transcribing medications in the absence of clinical knowledge of the person's condition other than a previous prescription. The SI explained that he checked the person's SCR or contacted the person's doctor to confirm the person was prescribed this medication. There was no evidence of this as the prescriber did not document patient consultations or communication with other HCPs. The SI referred to using NICE CKS summaries but not local antibiotic guidelines. And no prescribing audits were conducted. There were some printed questionnaire records annotated by hand to show the sale of some Phenergan liquid or the occasional POM had been refused.

The SI described the counselling he would provide if supplying a valproate to a person in the at-risk group and how he would record the intervention on the PMR or new Jelly Software. Obtaining warning cards to supply with high-risk medicines such as warfarin, methotrexate and steroids was discussed. The SI said he would try to avoid prescribing medicines requiring therapeutic monitoring such as warfarin. But he would record the INR and dates of blood tests. The SI had completed training to deal with anaphylaxis in line with the CityDoc PGD training and he knew the location of the nearest defibrillator.

The Aesthetics service was not operational at the time of the visit. And the travel vaccination clinic was operational but not offering yellow fever vaccinations yet. The PGDs were online, there was an SOP and records of the vaccination such as batch number and expiry date were maintained on the patient medication record (PMR) or new Jelly Software. This software would assist the SI to prescribe, keep notes and contact the person's regular doctor about any additional care the pharmacy provided. Regarding phlebotomy, the SI was trained to take samples and send these to one of three pathology laboratories where they were analysed. Samples were taken and sent to the laboratories on behalf of companies and individuals. The results were communicated to the person by email, phone and in person.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. And it date-checked stock when it was delivered by the suppliers and again every six months. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The fridge had a data-logger to monitor temperatures. And its CDs which did not require safe custody, were stored securely. The pharmacy could arrange a special collection of waste for sharps and obsolete medicines. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. The SI placed MHRA recalls in an email folder and particularly those relating to baby milk in last 6 months which the pharmacy. No records were kept of actions taken or effected stock returned.

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 could restrict the number of people it allowed in the premises at a time if needed. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment if needed. The SI had access to up-to-date reference sources. The pharmacy had a refrigerator and data logger to store pharmaceutical stock requiring refrigeration. Confidential waste was disposed of appropriately. There was equipment and SOPs to follow to test people's blood for HbA1c and cholesterol.

The pharmacy restricted access to its computers and patient medication record system. And only authorised persons could use them when they put in their password. The SI described the anaphylaxis kit which included adrenaline injection devices and the location of the nearest defibrillator. Maintenance of the blood pressure monitor was discussed.

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.