General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Smart Pharm Ltd, 787-789 Harrow Road, London, NW10 5PA

Pharmacy reference: 9011292

Type of pharmacy: Community

Date of inspection: 30/01/2023

Pharmacy context

The pharmacy is in a mixed commercial and residential area on Harrow Road near Kensal Green underground station in northwest London. The pharmacy dispenses private prescriptions and provides health advice. Services include phlebotomy, prescribing and weight management. It sells over-the-counter medicines from the pharmacy's premises. The pharmacy does not dispense NHS prescriptions or provide NHS services at this site.The aesthetics service is provided by the superintendent pharmacist of Smart Pharm Ltd. As this activity is taking place outside of the registered premises it is not included in the report.

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 routinely document the risk assessments for all the services it provides.
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 does not routinely document the risk assessments it completes for all its services. It has adequate standard operating procedures in place to manage risks and make sure its team members work safely. But these are due for review and may not reflect current best practice. The pharmacy generally keeps the records it needs to by law. It tries to follow up on people's feedback to improve its services. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) explained that since installing the new pharmacy computer system, the rate of picking errors had significantly reduced. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. The RP said there was a low volume of dispensing at this pharmacy. It did not have an NHS contract. People could give consent for their NHS prescriptions to be dispensed at the nearby branch of this pharmacy which was a closed pharmacy meaning people could not visit it in person so it delivered prescription medicines to people's homes. Alternatively, they could collect their prescriptions which were bagged and stored securely at this pharmacy. The pharmacy maintained delivery sheets which formed an audit trail so prescriptions could be located if there was a query,

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication. They referred to prescriptions when labelling and picking medicines. They scanned each item they had picked and the new pharmacy computer alerted them to incorrectly picked medicines which did not match what they had entered onto the new computer system when processing the prescription. The RP completed the clinical and final check of prescriptions and assembled prescriptions. Warning cards were added to give people information about their medicines. There was a procedure for supplying owing medicines to make sure people completed their treatment.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided and it had a business continuity plan. These were due to be reviewed to reflect any changes in practice. 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. They knew what they could and could not do, what they were responsible for and when they should refer to the RP. Their roles and responsibilities were described in the SOPs. And SOPs specified which pharmacist or member of the team a task was delegated to. One team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar medicines, such as medicines that could be misused, to a pharmacist.

The pharmacy had a complaints procedure. And it sent out feedback forms to people having deliveries. And it collected feedback in the form of online reviews. The RP checked negative feedback or

complaints and tried to contact those who were dissatisfied.

The pharmacy had hand sanitising gel for people to apply to help reduce the risks associated with COVID-19.. Following the visit the RP explained the risk assessment that was in place to identify the risks associated with the delivery service to people's homes on behalf of both pharmacies. For instance, people turned up at the closed pharmacy and had to be signposted to this pharmacy. The pharmacies both had contact details for service users so they could contact them about delivery issues.

The RP was the only practitioner who prescribed and administered treatments. And he did not have a formalised prescribing policy in place. But he did have a range of protocols and guidance for the prescribing and administration of treatments offered. It was highlighted to the RP that a prescribing policy would support consistency in provision of some services. He explained he used manufacturer’s information when prescribing Saxenda for weight loss. Following the visit, RP confirmed that he was in the process of creating and documenting risk assessments for the services provided including all the items he prescribed. The RP maintained records for prescribing, consultation and administration of services including treatment plans on a digital tablet device which was password protected.

The pharmacy displayed a notice that told people who the RP was and kept a record to show which pharmacist was the RP and when. The RP confirmed that the pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy had a controlled drug (CD) register. A random check of actual stock of one CD matched the amount recorded in the register. And the team recorded regular CD audits in the appropriate register. The RP explained that a record was kept in the CD register for receipt of all the CDs dispensed at the other pharmacy and sent to this pharmacy to be collected. This matter had been discussed with the previous CD accountable officer (AO) for London. The pharmacy kept records for the supplies of the unlicensed medicinal products it made although there did not appear to have been any recent supplies. The pharmacy recorded supplies it made on private prescriptions electronically although some information was incorrectly recorded.

The pharmacy was registered with the Information Commissioner’s Office and displayed a privacy notice. The information governance procedure was due for review. The pharmacy disposed of confidential waste paper securely. The team member at the medicines counter was aware of her role in protecting patient confidentiality. The pharmacy computer system was password protected. and not visible to people on the registered premises. There were NHS smartcards belonging to different team members in the dispensary. Ensuring the NHS smartcards were securely stored and used appropriately was discussed with the RP.

The pharmacy had a safeguarding SOP in which the RP trained team members so they knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And the RP had completed level 2 safeguarding training. The RP was aware of the NHS safeguarding App and both the RP and the delivery driver were disclosure and barring service (DBS) checked.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members are trained or in training relevant to their roles so they deliver services safely and manage the workload. And they understand their roles and responsibilities. Members of the team feel able to provide feedback on how the pharmacy could improve its services.

Inspector's evidence

The pharmacy team consisted of the RP (also superintendent pharmacist), a regular locum pharmacist who covered the RP’s days off, three part-time medicines counter assistants and a part-time delivery driver. One member of the team was a pharmacy student. The RP was supported at the time of the inspection by one team member who was at the medicines counter. Following the visit, the RP confirmed that team members were enrolled on accredited training course in line with their roles.

The RP provided some training at the start of their employment. And this included the need to keep people’s private information safe and being able to explain the services on offer. The RP was an independent prescriber and had specialised in providing an aesthetics service. He had displayed certificates for membership and attendance at a range of training courses. He also prescribed weight loss medications and anti-microbials to manage post-operative infections.

The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an over-the-counter (OTC) sales SOP which its team needed to follow. This described the questions the team members needed to ask people when making the OTC recommendations. And they knew when to seek advice from a pharmacist. They were comfortable about making suggestions on how to improve the pharmacy and its services and how to raise a concern with if they had one. The team had a WhatsApp group to communicate with each other and they could record notes on the pharmacy computer system.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy was well presented and had a spacious retail area, a counter, and a small dispensary. The pharmacy’s consultation room was clean, tidy and signposted, so people could have a private conversation with a team member. The registered pharmacy premises had a sign advising the availability of a chaperone. The dispensary had limited workspace and storage available. Worksurfaces in the dispensary were clean and clear. There were treatment rooms at the back of the pharmacy but these were not part of the registered premises. People accessed the treatment rooms via the pharmacy. The website for the services in these treatment rooms was not linked to the registered pharmacy and as such is outside the jurisdiction of GPhC.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services more easily accessible to a wider range of people by staying open later than is usual. It obtains its medicines from reputable suppliers and stores them securely at the right temperature, so they are safe to use. The pharmacy identifies people using high-risk medicines and makes sure they have the information they need to use their medicines safely. Team members know what to do in response to alerts and product recalls and return any medicines or devices to the suppliers. But it does not do enough to share information with people's usual doctor so that they would know what treatments people have been given.

Inspector's evidence

The pharmacy had a wide automated door and its entrance was level with the outside pavement. This made it easier for people who found it difficult to climb stairs or who used a wheelchair, to enter the building. The pharmacy team understood or spoke languages which included Portuguese, Arabic and Persian to assist people whose first language was not English. They could print large font labels for people with visual impairment and the pharmacy had a hearing loop. The RP explained that the opening hours made the pharmacy services available to more people. The pharmacy team signposted people to another provider if a service was not available at the pharmacy.

The pharmacy provided a delivery service to people who could not attend its premises in person. Some of those deliveries were of prescriptions dispensed by the owner's other pharmacy nearby, which people could not visit in person. It kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacist explained that people could nominate the nearby branch of the pharmacy giving consent for their NHS prescriptions to be dispensed there and be delivered to their homes or to this pharmacy to be collected.

Members of the pharmacy team could identify who had prepared a prescription. The pharmacist who dispensed people's NHS prescriptions initially provided counselling and follow up in line with the new medicines service for people prescribed new medicines. The pharmacy had warning cards for high-risk medicines to give to people so they had the information they needed to take these medicines safely. They were aware of the valproate pregnancy prevention programme. And 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.

The RP was an independent prescriber and he explained his prescribing was limited to prescribing for the services he provided such as Saxenda for weight management. And that he did follow local prescribing guidance if prescribing antibiotics. The RP initially prescribed Saxenda after a face-to -face consultation checking weight and height of the person to make sure they fit the criteria for the service. He kept consultation notes for each person on the tablet device so he was able to monitor repeat treatment requests and use his professional judgement if he had concerns. The RP followed the manufacturer's chart to prescribe repeat treatment. He monitored height and weight or stomach

circumference.

If the RP had any concerns regarding mental or physical health, he referred the person to their own doctor. But the RP did not routinely inform people's usual doctors about treatments they received from the clinic. The pharmacy provided a private phlebotomy service in the pharmacy's consultation room. The RP collected blood samples and these were sent via courier to a laboratory for analysis. People could have their blood pressure and blood glucose tested too.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock and ancillary items such as syringes. It kept most of its medicines in their original manufacturer's packaging. The dispensary was very tidy. The pharmacy team kept records of regular checks of the expiry dates of medicines. 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 securely in line with safe custody requirements. The pharmacy's waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described 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 and keeps people's private information safe.

Inspector's evidence

The pharmacy had hand sanitiser for people to apply. And it had the personal protective equipment its team members needed. The pharmacy had a plastic measure for use with liquids, and ensuring it was appropriate for measuring certain liquids such as CDs was discussed. The pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The consultation room was tidy. There were two chairs and a desk. There was a sharps bin to safely dispose of sharps in connection with services. The RP had adrenaline ampoules and syringes and prefilled adrenaline syringes to deal with anaphylaxis. The pharmacy disposed of confidential waste appropriately. It restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team.

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.