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: 04/01/2024

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. It sells over-the- counter medicines from the pharmacy's premises. Services include phlebotomy, prescribing and weight management.
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 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

Overall, the pharmacy delivers its services safely. It has adequate standard operating procedures in place to manage risks and make sure its team members work effectively. The pharmacy mostly keeps the records it needs to by law. It tries to follow up on people's feedback so it can improve its services. Members of the pharmacy team protect people's private information, and they understand their role in protecting 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. The computer system automatically recorded mistakes which could be collated to create a report. Members of the pharmacy team discussed their mistakes to learn from them and help avoid them happening again. They separated medicines which were similar in some way to minimise picking errors. The RP explained that there was a low volume of dispensing as the pharmacy did not have an NHS contract. But people could give their consent for NHS prescriptions to be dispensed at the nearby branch of this pharmacy. It was a closed pharmacy meaning people could not visit it in person, but it provided a delivery service to people's homes. They could also collect their prescriptions which were bagged and stored securely at this pharmacy. The pharmacy-maintained a delivery 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 people's medicines and prescriptions. They entered prescription information onto the pharmacy's computer and scanned the barcode on each medicine they picked. The pharmacy computer alerted them to incorrectly picked medicines which did not match what they had entered onto the computer system. The RP took a mental gap between dispensing and checking if working alone. And he completed the clinical and final check of prescriptions. And bagged prescriptions were marked to indicate that a medicine needed to be added such as a controlled drug (CD) or a fridge item. There was a procedure for supplying owing medicines to make sure people completed their treatment. Members of the team checked people's dates of birth to make sure they were handing out prescriptions for the right people.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided, and it had a business continuity plan. These were reviewed to reflect any changes in practice and included RP procedures. 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. 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 the pharmacy team members referred any concerns to the RP who was also the superintendent pharmacist (SI). People could leave reviews online. The RP monitored Google review and tried to contact those who were dissatisfied to follow up negative feedback or complaints.

The pharmacy had hand sanitising gel for people to apply to help reduce the risk of infection. The RP had risk assessments (RA) in place to identify and manage the risks associated with providing services. He explained how following an incident, he reviewed the equipment and how it was used to deliver one of the services on offer. And updated the RA to reflect changes to the equipment and how it was operated. The RP explained the risk assessment 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 maintained a delivery audit trail and both had contact details for service users so they could contact them about delivery issues. The trained delivery person was criminal records bureau (CRB) checked but deliveries were also completed by the RP or another team member. The RP was aware of updated rules for dispensing valproates.

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 insurance arrangements in place, including professional indemnity, for the services it provided. The RP was the only practitioner who prescribed and administered treatments. He did have a range of protocols and guidance for the prescribing and administration of treatments offered. 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 maintained records of interventions and consent on the patient medication record (PMR).

The pharmacy had a controlled drug (CD) register and the CDs were audited regularly. A random check of the actual stock of one CD matched the amount recorded in the register. The RP explained that he kept a record in the CD register for receipt of all the CDs dispensed at the other pharmacy but sent to this pharmacy to be collected. This matter had been discussed with the previous CD accountable officer (AO) for London. The pharmacy had records for the supplies of the unlicensed medicinal products it made. The pharmacy recorded supplies it made on private prescriptions electronically.

The pharmacy was registered with the Information Commissioner’s Office and displayed a privacy notice. It disposed of confidential wastepaper securely. A 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. The RP had completed level 2 safeguarding training and described safeguarding scenarios in relation to refusing treatments for people under 18 years old, even when they had a parent with them who provided consent. The SI verified ages by asking for identification documents when he felt this was necessary. The registered pharmacy premises had a sign advising the availability of a chaperone. The RP was signposted to the NHS safeguarding app.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are enrolled on accredited training in line with their roles to help make sure they deliver services safely and manage the workload. Members of the team understand their roles and responsibilities. They 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, three part-time medicines counter assistants enrolled on accredited training or on probation and a part-time delivery driver. The RP was supported at the time of the inspection by one team member who was at the medicines counter. The RP confirmed that the driver was CRB checked and on a Centre for Pharmacy Postgraduate Education (CPPE) delivery driver training course.

The RP provided some induction training to newly recruited team members. 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 sale and supply of medicines and advice given by the pharmacy team. The pharmacy had an over-the-counter (OTC) sales SOP which its team members were trained to follow. This described the questions the team members needed to ask people when making the OTC treatment recommendations. And they knew when to seek advice from a pharmacist. The RP conducted appraisals annually to monitor team member's training needs. They were comfortable about making suggestions on how to improve the pharmacy and its services and raising a concern if they had one. The team had a WhatsApp group to communicate with each other.

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 there was air conditioning 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 displayed a notice 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's premises 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 stays open later than is usual and makes its services easily accessible to people with different needs. It obtains its medicines from reputable suppliers and stores them securely at the right temperature, so they are fit for purpose. The pharmacy makes sure people using high-risk medicines have the information they need to use their medicines safely. But it does not routinely share treatment information with people's usual doctor so that their patient medication record is complete. Team members know what to do if they get alerts or recalls and have to return affected medicines or devices to the suppliers.

Inspector's evidence

The pharmacy had a wide automatic entrance door and step free access from the outside pavement. This made it easier for people who found it hard to climb stairs or who used a wheelchair, to enter the building. The pharmacy team understood or spoke languages such as Arabic to assist people whose first language was not English. They could print large font labels which people could read more easily and the pharmacy had a hearing loop. The pharmacy's opening hours made its 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 deliveries were for 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 including multicompartment compliance packs. Prescriptions were 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 a follow up in line with the new medicines service for people prescribed new medicines. The pharmacy had warning cards for high-risk medicines, such as steroids, to give to people so they had the information they needed to take these medicines safely. The RP was aware of the new rules for dispensing a valproate and counselling people in the at-risk group on the pregnancy prevention programme.

The RP was an independent prescriber and he explained his prescribing was limited to prescribing for the services he provided such as Saxenda and Wegovy, both licensed for weight management. And that he did follow local prescribing guidance if prescribing antibiotics. The RP usually conducted face-to-face consultations in his unregistered office. Then he checked age, weight and height of the person to make sure they met the criteria for the service. And prescribed Saxenda if appropriate. The pharmacy also offered fat dissolving injections. The RP 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. And documented decisions to refuse treatment. He could access the person's summary care record (SCR). The RP followed the manufacturer's chart to prescribe repeat treatment. He monitored height and weight or stomach circumference, provided post-treatment guidance and was

contactable 24 hours a day in the event of an emergency due to receiving treatment. 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. Although there was an option on the iPad to fill in the details of the GP if people wished for the information to be shared, the RP said hardly any people saw it as necessary.

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. The pharmacy team had access to up-to-date reference sources such as Medicines Complete. The pharmacy had a refrigerator to store pharmaceutical stock requiring storage between two and eight Celsius. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The consultation room was tidy. There were two chairs, a desk and sharps bin to safely dispose of sharps in connection with services. The RP had adrenaline ampoules, 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.