General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacierge Pharmacy, Lower Ground floor, 8 Wimpole Street, London, W1G 9SP

Pharmacy reference: 9011295

Type of pharmacy: Community

Date of inspection: 28/04/2021

Pharmacy context

This pharmacy is situated in Westminster close to Harley Street. Its main activity is dispensing prescriptions for private GPs and Consultants working in the London area and throughout the UK. The pharmacy promotes its services via its website www.pharmacierge.com. The pharmacy does not dispense any NHS prescriptions and it rarely sell over the counter medicines. People do not usually visit the pharmacy in person and most prescription medicines are delivered by courier. The inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 adequately manages the risks associated with its services. The pharmacy team keeps the records it needs to by law and it protects people’s personal information. The team members work to professional standards. Lines of accountability and the pharmacy's working procedures are clear. And team members understand their role in safeguarding vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered its operational activities. These were tailored to the business and training logs identified which members of the pharmacy team had read and accepted them. The SOPs were due to be reviewed and updated in the near future. The superintendent pharmacist (SI) had been working remotely during the pandemic, but he was in regular contact with the pharmacy team. A pharmacist manager worked full-time and supervised the day-to-day operation of the pharmacy. Staff roles were clearly defined, and a chart displayed in the dispensary identified who was responsible for what. Individual team members clearly explained their responsibilities and were aware of the limitations of their roles.

The pharmacy had covid secure procedures in place. Pharmacy team members had completed Buttercups pandemic training in May last year. All team members had received at least their first covid vaccination with some having had their second dose. Lateral flow tests were completed prior to commencing work each day. Team members used hand sanitiser regularly and wore face masks whilst working. A facial temperature scanner was used so team members and anyone accessing the pharmacy could be monitored.

Prescribers could opt to register with the pharmacy so they could offer the pharmacy’s prescription fulfilment service to their patients. Prescriptions were sent to the pharmacy electronically via the pharmacy’s e-prescribing platform linked to the website. Alternatively, the pharmacy’s prescribing platform was linked to one of the commonly used clinic practice systems, so prescribers could access it directly from this if they used it. Prescriptions contained an electronic signature which was unique to the prescriber. The pharmacy also accepted prescriptions via fax, scan, and secure email providing the original prescription was then sent to the pharmacy.

When registering for the service, prescribers were required to provide details of their General Medical Council (GMC) registration or equivalent, and the registered address of their practice. Biometric facial recognition checks were completed matching their face with their photographic identity document. Verification checks were completed to ensure they were licensed to practice, and these checks were completed annually in case of changes in a person’s prescribing status. The pharmacy also occasionally monitored the GMC website for hearing decisions in case of changes to a doctor’s circumstances. The pharmacy reported one occasion when a doctor had relinquished his license to practice but continued to prescribe; the pharmacy had acted immediately to prevent further supplies once they were aware of this. Most of the prescribers that the pharmacy worked with were registered with the GMC. Occasionally they received a prescription from an EU prescriber, and these were considered on an individual basis.

The pharmacist said they could not always be dispensed as it could be difficult to verify the prescriber’s

registration. The pharmacy dispensed prescription for a few nurse prescribers who worked in specialist areas such as fertility.

The pharmacy identified and managed risks in the dispensing process by recording and learning from incidents and near misses. Team members were asked to rectify their own near miss errors. Near misses attributable to an individual team member were collated and emailed to them at the end of each month so they could identify their own learning needs. Common near miss errors and any dispensing incidents were discussed at monthly team meetings. Flags were used on the PMR system to highlight common picking errors. Team members had completed training on look-alike-sound-alike (LASA) medicines. An incident involving the theft of a courier motorbike which was carrying medicines for delivery had been investigated and reported to the CD accountable officer. The team had implemented extra screening checks after a doctor alerted them to a patient who was reordering their repeat prescription for benzodiazepines too frequently.

The pharmacy's complaints procedure was explained on the website. Complaints were initially handled by the pharmacy manager but could be escalated for a more formal response from the SI if needed. The pharmacy manager said they logged and discussed all complaints to understand what action was needed in order to resolve them. The pharmacy was also responsive to online reviews. Any learning from complaints was shared with the wider team.

Professional indemnity insurance was in place and valid certificate was displayed in the pharmacy. The pharmacy accurately maintained a paper based responsible pharmacist (RP) log and an RP notice was displayed near to the entrance, so it was visible to people entering the pharmacy. The pharmacy used a recognised patient medication (PMR) system to record prescription supplies and generate labels. Private prescription records were integral to the PMR system and a sample checked were in order, except occasional prescriber details and/or their addresses were missing. The pharmacist agreed to ensure this was rectified. The pharmacy maintained and electronic CD register; entries could only be made by the pharmacists. Weekly CD balance checks were completed by the pharmacist. The pharmacy provided a couple examples of specials records which were completed when unlicensed medicines were supplied. The pharmacy used a bespoke software system record the prescription journey including any interaction with the prescriber and patient.

All team members had completed information governance and General Data Protection training. Computer systems were password protected with each team member having an individual log in. E-prescriptions and emails were encrypted and transferred securely. Confidential waste was segregated and collected by an authorised contractor. A shredder was available for immediate use. A privacy policy was available on the website.

All staff had completed formal safeguarding training, so they were aware of the potential issues and how to escalate serious concerns. The pharmacy team had limited face-to-face contact with patients, but they could contact them by telephone and email. The pharmacy aimed to telephone all people over 70 to help them with payments. This approach had enabled them to identify when a regular patient was becoming more confused, and they had alerted their doctor to this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage the workload. The pharmacy team members have the right qualifications for their roles and they are able to develop their skills by completing additional training. The team members work well together in a supportive environment.

Inspector's evidence

Team members worked two overlapping shifts; 7.30am-4.30pm and 10am-7pm. Dispensary tasks were rotated on a daily basis and allocated according to a rota. Dispensary team members were trained to complete all task in the dispensing process including prescription administration and assembly. Absences such as holidays were planned and there was enough flexibility in the team to provide ad hoc cover. Some team members said it had been difficult at the start of the pandemic as the pharmacy had also experienced a sudden increase in demand as well as staff sickness and people having to isolate. But the additional team members had been recruited and they felt the situation was much better and that the workload was manageable.

Team members had all completed or were in the process of completing accredited training for their roles. The pharmacy used Buttercups courses when training staff. An NVQ2 dispenser had recently been recruited and was undergoing her induction. The pharmacy did not routinely sell over-the counter medicines and so the MCAs mainly packed dispensed prescriptions ready for dispatch, received deliveries and greeted people at the front counter.

Several team members were being supported to complete additional training: one of the dispensers had progressed and was completing their NVQ3. Two of the pharmacists were in the process of completing a prescriber course and another was undertaking a clinical diploma.

Team members spoke openly and positively about their experience whilst working at the pharmacy. They felt well supported. Regular team meetings were held, and team members felt able to contribute ideas. They were confident they could approach a member of the management team if they had concerns. The pharmacist said a whistleblowing procedure was included in the SOPs. Some customer service targets were set for the team to make sure the service was running smoothly, But these were not incentivised and the pharmacist felt able to exercise their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the services it provides. It is clean, secure and well maintained.

Inspector's evidence

The pharmacy was located in the basement of a converted Georgian townhouse. It could be directly accessed from the street via stairs from pavement level. The upper floors were used as business premises and accessed separately.

The pharmacy consisted of the main dispensary with additional areas dedicated to administration, accounts and staff rest facilities. The dispensary was fitted with shelving and work benches. Different areas were allocated to specific activities and it was reasonably tidy and well organised. Fittings were in good order and air conditioning controlled the ambient room temperature.

The pharmacy’s website was simple in design and contained key information about the service. It had a log in function which could be used by prescribers once they had registered as users of the service.

The pharmacy operated a closed-door policy. Screens were installed at the front counter and reception area as an extra infection control measure. The premises were suitably secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally operates a safe and efficient service, so people usually receive their medicines on time. The pharmacy sources and stores its medicines appropriately. And the team carries out checks to help make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy's opening hours were Monday to Friday 9am-7pm. People could request that their doctor send their prescription to the pharmacy. Or prescribers registered with the pharmacy could offer the service as an option when issuing a prescription. The pharmacy used email, text and the telephone to contact patients and prescribers. The pharmacy's contact details were available on the website. Most medicines were delivered directly to people's homes by courier with same day delivery in the London area and next day elsewhere in the UK. Couriers were given instructions when they commenced working with the pharmacy and they had to agree terms and conditions around the safe delivery of medicines and patient confidentiality.

The pharmacy occasionally supplied people who were living overseas, usually ex-pats whose doctor was based in the UK, and these were managed on a case-by-case basis considering their country of residence and local custom restrictions. People visiting local clinics sometimes visited the pharmacy in person to have their medicines dispensed although this was relatively uncommon. A small sign at street level signposted them to the pharmacy's location and a buzzer at the door was used to request access. The pharmacy supplied occasional discharge medications for a local clinic with inpatient facilities. Otherwise, they rarely supplied medicines directly to clinics or prescribers unless they required professional administration, such as vaccines.

Most prescriptions were sent electronically. They were screened and processed initially by pharmacy technicians so any issues could be resolved. Prescriptions were entered on the PMR system and labels were generated. Payment was then requested; a payment could be made over the phone or a link could be sent by email or text. Once payment was received, prescriptions were assembled before a final clinical and accuracy check by one of the pharmacists. Completed prescriptions were sent to be packaged and made ready for dispatch.

Patient leaflets were supplied, and additional written information was provided with high-risk medicines such as methotrexate, lithium and valproate. The pharmacy team did not routinely check these patients were being monitored as they were usually under the care of a consultant. But they made extra checks if several months' supply was prescribed at a time. The pharmacy had completed audits for flu and diabetes in keeping with the national NHS audit. The pharmacy had not completed a valproate audit to identify if there was anyone receiving regular medication in the at-risk group, but the pharmacy manager agreed to complete this so they could provide extra counselling if necessary.

The pharmacy supplied a number of CDs. Supplies were only made once the original prescription was received. FP10PCD forms were submitted to NHSBSA on a regular basis.

Plastic containers were used to separate prescriptions to prevent them becoming mixed up during the dispensing process. A copy of the prescriptions and relevant paperwork were clipped together following

screening and a QR code was generated for each order. Team members could scan this at any stage in the process to quickly access the order record details on the pharmacy's IT system. This record contained additional details including communications with the prescriber and patient, and it allowed the team to track prescriptions through to the point of delivery. Details of delivery times and photos as confirmation of delivery could be accessed. Pharmacists said they often spoke to patients on the telephone and people could also request a call when making their payment. Call waiting and answering times were monitored.

The pharmacy obtained its medicines from recognised licensed wholesalers or suppliers. Medicines were stored in their original packaging and dispensary shelves were reasonably tidy. CDs requiring safe custody were stored in cabinets. Access to the was controlled by the pharmacists. Obsolete CDs were segregated. CD destructions were recorded and completed using denaturing kits. Other waste medicines were segregated in designated bins before being collected by an authorised waste contractor. The maximum and minimum fridge temperatures were monitored and recorded to make sure they remained within a suitable range. Medicine and medical device alerts were received by email and distributed by the SI. A nominated individual made sure these were actioned if necessary and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy team had online access to the British National Formulary and MedicinesComplete and could access the internet for the most up-to-date information. There were medical fridges and CD cabinets used for storing medicines.

Hand sanitizer gels were readily available to help with infection control. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had equipment for counting loose tablets and capsules. The pharmacy packed medicines in cardboard boxes so they were protected and opaque bags were used to dispatch medicines. Cold chain packaging was used for fridge lines, with different options for same day and next day delivery to ensure the integrity of the medicine was maintained.

The pharmacy had numerous workstations with computer screens enabling team members to easily access the pharmacy’s IT systems. Telephones were located throughout the premises so team members could contact patients or prescribers if needed. All electrical equipment appeared to be in good working order.

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.