General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rightcare Pharmacy, 29 Park Parade, Harlesden, London, NW10 4JG

Pharmacy reference: 9011349

Type of pharmacy: Internet / distance selling

Date of inspection: 21/04/2022

Pharmacy context

The pharmacy is in a busy commercial and residential area in northwest 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. It provides a delivery service and supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. The pharmacy re-located to its present site in March 2020. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
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.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy team members do not provide people with all the information they need to take medicines in compliance aids safely. The pharmacy team does not always keep records of fridge temperatures to show stock is stored correctly and fit for purpose. The pharmacy fridge is not working properly.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written instructions which tell the team members how to complete tasks safely. But the pharmacy has not kept these sufficiently up to date so they may not reflect current best practice. Members of the pharmacy team do not always record their mistakes to learn from them and to help prevent similar mistakes happening again. Otherwise, the pharmacy team member's working practices are generally safe and effective. They have introduced ways of working to help protect people and minimise the risk of COVID-19 infection. The pharmacy mostly keeps all the records it needs to by law. 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 a system to review dispensing errors. The superintendent pharmacist (SI) was also responsible pharmacist (RP) and worked alone or with the registered pharmacy technician. The pharmacy team members discussed the mistakes they made when they were picking medicines for dispensing. As a result, they sometimes rearranged medicines stock, and medicines which were similar in some way such as lansoprazole capsules and tablets were separated from each other in the dispensary to minimise picking errors. The pharmacy's team members did not record their near misses so they may miss opportunities to spot trends, learn from them and reduce the chances of the same mistakes happening again.

The pharmacy team used baskets, when they were making up people's prescriptions, to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products and checked interactions between medicines prescribed for the same person. Assembled prescriptions were not dispatched for delivery to people until they were checked by the RP. There was a procedure for dealing with medicines which the pharmacy owed to people. Most prescriptions were sent to the pharmacy via the electronic prescribing service (EPS) but a small number of private prescriptions were processed. The SI described checks which were made if necessary, such as registration check of the prescriber and patient identity.

The pharmacy had distance-selling standard operating procedures (SOPs) for most of the services it provided. And they included complaints and responsible pharmacist 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. But the SOPs required updating and team member's last training records were dated 2019. The delivery person had read and signed the SOPs relevant to the role but needed to complete training on the information governance procedure. The SI explained that there were very few sales of over-the-counter (OTC) medicines and these were delivered with the person's prescription. No records were maintained for OTC sales. The pharmacy generally received feedback from its service users by email.

The SI had risk-assessed the impact of COVID-19 upon its services and the people who used it. But he had not recorded the risk-assessment or a business continuity plan to manage changes to the

pharmacy's services. The SI knew that any work-related infections needed to be reported to the appropriate authority. To minimise the risk of infection during the deliveries, the driver had personal protective equipment (PPE) and the delivery procedure had been adjusted although not documented. People informed the pharmacy if they had tested positive for COVID-19 so that the delivery would be contactless. The delivery schedule was organised according to post code.

The pharmacist was reminded to display a notice showing the details of who the RP was. The RP record was mostly complete to show which pharmacist was the RP and when. Following the visit, the SI gave an assurance that he had completed the small number of missing entries. 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 the actual stock of a CD matched the recorded value. The pharmacy completed records for the supplies of the unlicensed medicinal products it made although there were no recent records. But the records it did have showed when one of these products was received and who it was supplied to and when. The pharmacy recorded the private prescriptions it supplied. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. Keeping records of risk-assessments, changes in procedure and near misses was discussed with the SI as this would mean the team members could refer to and learn from them.

The pharmacy was registered with the Information Commissioner's Office (ICO). It displayed a notice on the website that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy computer was password protected. The team member's own NHS card was in use and the SI had completed the data security and protection toolkit. The pharmacy team collected confidential wastepaper to be disposed of securely. And the SI and the pharmacy technician had completed a level 2 safeguarding training course. 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.

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 can make suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (also RP) who was full-time, a full-time registered pharmacy technician. and a part-time delivery driver. The SI had completed Centre for Pharmacy Postgraduate education (CPPE) training for dealing with 'lookalike and soundalike' (LASA) medicines and risk management. He allocated protected learning time for the pharmacy technician to prepare for annual renewal of GPhC registration. Team meetings and appraisal of the team member's performance were informal. The SI updated the pharmacy technician on topics such as COVID-19 information. The pharmacy technician was able to make suggestions to improve services. And had suggested a new way to plan delivery schedules by arranging them by post code. Deliveries were mainly local as people who accessed pharmacy services lived locally to the pharmacy. The SI was signposted to the Pharmaceutical Services Negotiating Committee (PSNC) for information on training and delivery of the discharge medicines service (DMS), the Community Pharmacist Consultation Service (CPCS) and the GPhC Knowledge Hub.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not display enough up-to-date and accurate information on its website. The pharmacy's premises are generally clean and secure. The design and layout of the pharmacy is suitable for the nature of 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. The pharmacy's team members working practices help protect people from COVID-19 infection.

Inspector's evidence

The registered pharmacy's premises were more spacious than the previous premises. The pharmacy did not have an automated door. There was a long corridor from the entrance to the pharmacy which did not have a retail area. The dispensary was in a separate room at the back of the premises. There was a 'galley' shaped room to one side of the dispensary which was being used as a preparation room for multi-compartment compliance aids. And it was a consultation room for people accessing private services. It protected the privacy of people when the door was closed. Steps were taken to make sure the pharmacy and its team didn't get too hot. The pharmacy's premises had a sink. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy.

The SI demonstrated the website which displayed information relating to the pharmacy such as the owner's name, GPhC pharmacy number, the pharmacy's name and address, details of how to complain and record consent. But some details were out of date or incomplete and included reference to a prescribing service although it was unavailable. And it was not clear who was SI or how to check the registration status of the pharmacy and the SI. The website displayed over-the-counter medicines for sale although the SI explained that there were no online sales of medicines. To ensure the website was secure and met information security management guidelines the SI was signposted to the ICO website. And to help make sure the website would meet the standards in principle 3 the SI was signposted to the GPhC Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet (Updated March 2022).

Principle 4 - Services **Standards not all met**

Summary findings

Members of the team do not always record the fridge temperatures to show fridge items are stored correctly. And they do not always provide patient information leaflets and a description of the medicines in a compliance aid so people have all the information they need to use their medicines safely. But otherwise, the pharmacy's working practices are generally safe and effective. 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 team members know what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy was not open for people to visit in person, so people did not generally have face to face contact with the pharmacy members. There was an ‘A’ board at the pharmacy’s entrance which displayed the pharmacy name and contact details. Members of the pharmacy team could speak or understand Somali and Arabic to assist people who did not speak English as their first language. They signposted people to another provider if a service wasn’t available at the pharmacy. For instance, people were directed to other local pharmacies for emergency hormonal contraception.

The pharmacy offered a managed repeat prescription service. And people could order their prescriptions through the pharmacy. The SI completed the clinical and final check on prescriptions before they were delivered. Interactions between medicines prescribed for the same person were checked online or with the prescriber. The pharmacy recorded interventions such as blood test dates on the patient medication record (PMR). The pharmacy provided a delivery service to people because they 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 person. The registered pharmacy technician delivered CDs to people. The pharmacy team packed delivery items requiring refrigeration in a tote box with a cold pack.

The pharmacy used a disposable pack for people who received their medicines in compliance aids. The pharmacy team checked whether a medicine was suitable to be re-packaged. It didn’t provide a brief description or patient information leaflets (PILs) for each medicine contained within the compliance packs. So, people didn’t always have the information they needed to make sure they took their medicines safely. Members of the pharmacy team initialled the dispensing labels on medicines, so they knew which of them prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about their medication or if other items needed to be added before delivery. The SI generally provided counselling to people by phone such as reminding people to have the blood tests they needed if they took medicines which had to be monitored. The RP knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications and was aware of the valproate pregnancy prevention programme. The pharmacy had the valproate educational materials such as PILs to give to people. The SI said he would order

educational materials for other high-risk medicines such as steroids and methotrexate.

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. But the dispensary wasn't as tidy as it could have been in places. The pharmacy team checked the expiry dates of medicines a few times a year. It didn't record when it had done a date-check. But no date-expired medicines were found on the shelves in a random check. The pharmacy had a medical fridge to store its stock which needed to be refridgerated between two and eight Celsius. On the day of the visit, the fridge was showing an overall temperature within range but the upper temperature was out of range. And members of the team regularly checked the maximum and minimum temperatures of the refrigerator. But they didn't always record these. The SI said he would contact the manufacturer to check about fridge reset and maintenance. The pharmacy stored its CDs securely. The pharmacy had procedures for handling the unwanted medicines. And these medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the SI described the actions they took 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 team had access to up-to-date reference sources. 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 one glass measure for use with liquids and the benefits of having a spare measure in case of breakage was discussed. The electrical equipment was Portable appliance tested (PAT). The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. The pharmacy had a shredder. So, its team could dispose of confidential waste appropriately. The pharmacy 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's team members were using 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.