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: 24/08/2023

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 packs for people who have difficulty managing their medicines. The pharmacy was inspected as a follow up to completing an action plan issued after the previous visit.

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

The pharmacy has suitable written instructions to help identify and manage risks in providing its services. But they have not been reviewed regularly so they may not always reflect current best practice. Members of the pharmacy team do not routinely record their mistakes to learn from them and to help prevent the same mistakes happening again. Overall, the pharmacy team's working practices are generally safe and effective. The pharmacy mostly keeps the records it needs to by law. Members of the pharmacy team keep people's private information safe and understand their role in protecting vulnerable people.

Inspector's evidence

The superintendent pharmacist (SI) was also responsible pharmacist (RP) and either worked alone or with the registered pharmacy technician (RPT). They explained that they discussed the mistakes they made when they were picking medicines for dispensing. The pharmacy's medicines were mostly arranged alphabetically on the dispensary shelves. And a few medicines which were similar in some way, such as amitriptyline or amlodipine, were separated from each other in the dispensary to help reduce the chance of picking errors. The pharmacy had a system to review near misses in the dispensing process. But 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 website displayed the complaints procedure.

The pharmacy team used baskets to separate each person's medication and to help them manage their workflow when they were making up people's prescriptions. The SI and the RPT referred to the 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 SI. There was a procedure for dealing with medicines which the pharmacy owed to people. Most prescriptions were sent to the pharmacy via the electronic transfer and a small number of private prescriptions received in the post were processed. The SI described checks which were made if necessary, such as registration check of the prescriber and patient identity.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. These were overdue for review and team members were due to retrain in the SOPs relevant to their role and update training records. Members of the pharmacy team were required to read and sign the SOPs to show they understood them and would follow them. The SI had not always included some information relating to actual practice or the date and author of preparation of the SOPs. For instance, the delivery SOP did not reflect some aspects of actual practice. Risk-assessments conducted by the pharmacy to help identify and manage risks associated with its services were discussed with the SI. And audits would help the pharmacy team to monitor safety and quality of services. The pharmacy had a complaints procedure. And people could leave feedback online. The SI was aware of the sodium valproate audit to monitor people in the at-risk group who took a valproate and ensure they received the information they needed to take medicines safely.

The pharmacy displayed the RP notice to tell people who was the RP and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place,

including professional indemnity, for the services it provided. The pharmacy had a controlled drug (CD) register. And the pharmacy team checked the actual CD stock to make sure it matched what was recorded in the CD register. But auditing the CDs more often was discussed so the pharmacy team didn't miss the opportunity to spot mistakes quickly. The pharmacy kept records for the supplies of the unlicensed medicinal products it made and it recorded when one of these products was received, 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 was sometimes incorrectly recorded.

The pharmacy was registered with the Information Commissioner's Office. Its website displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The RP said that if people needed to make a payment, the money was generally transferred direct to the bank. The RP had completed a level 2 safeguarding training course. Members of the pharmacy team knew what to do if they had concerns about the safety of a child or a vulnerable person. The RP was signposted to the NHS safeguarding App.

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 full-time superintendent pharmacist (also RP), a full-time registered pharmacy technician and who was the delivery driver depending on the workload. The SI allowed some protected learning time for the pharmacy technician to prepare for annual renewal of GPhC registration. Team member appraisal was informal. The pharmacy technician was able to make suggestions to improve services. And before the previous visit, he had suggested planning delivery schedules by post code which was still how the pharmacy organised the majority of deliveries. Deliveries were mainly local as people who accessed pharmacy services lived nearby. The SI was signposted to the GPhC Requirements for the education and training of pharmacy support staff and the GPhC Knowledge Hub.

Principle 3 - Premises ✔ Standards met

Summary findings

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.

Inspector's evidence

The registered pharmacy’s premises were spacious. The pharmacy had a manual door and a long corridor from the entrance at the street to the pharmacy. It did not have a retail area. The dispensary was in a separate room and there was a ‘galley’ shaped room to one side of the dispensary which was being used for preparation of multi-compartment compliance packs. And it was a consultation room for people accessing private services. It protected the privacy of people when the door was closed. The pharmacy team members were given advice to make sure any patient sensitive information is not visible to people who should not see it. Steps were taken to make sure the pharmacy and its team did not 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 website displayed information relating to the pharmacy such as the owner’s name, GPhC pharmacy number, the pharmacy’s name and address and details of how to complain. It also displayed over-the-counter medicines for sale although the SI explained that there were no online sales of medicines. The SI said the minor amendments to information on the website would be addressed. To help make sure 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 met 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 met

Summary findings

People can easily access the pharmacy and its services. And overall, the pharmacy's working practices are generally safe and effective. Members of the team do not always provide a description of the medicines in a compliance pack so people may not be able to identify individual medicines that they are taking. 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 to the public, so people did not generally have face-to-face contact with the pharmacy members. There was an advertising board at the pharmacy's entrance which displayed the pharmacy name and contact details. Members of the pharmacy team could speak or understand Swahili, Somali and Arabic to assist people who did not speak English as their first language. They signposted people to another provider if a service was not available at the pharmacy. For instance, people were directed to other local pharmacies for travel and flu vaccinations.

The pharmacy provided a delivery service three times per week to people because they could not attend its premises in person. But the pharmacy delivered prescriptions for antibiotics the same day. The pharmacy sorted and delivered prescriptions to people in the same postcode. It contacted some people prior to delivery to make sure they were in or to provide advice and counselling on their medicines. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The RPT delivered CDs to people. The pharmacy team packed delivery items requiring refrigeration in a tote box with a cold pack although most deliveries were nearby.

The pharmacy reminded people who could not use the NHS App to order their own prescriptions. 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 on the patient medication record (PMR). The SI explained that the pharmacy highlighted information from the doctor to the patient or called the patient or carer to pass on information from the doctor and to provide any counselling. The SI said that they did not ask people taking warfarin for their INR because the surgery would not release the prescription unless they had been informed of the latest INR value. The SI 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 valproate educational materials such as patient information leaflets (PILs) to give to people. And it had information cards for other high-risk medicines such as steroids and methotrexate.

The pharmacy used a disposable pack for people who received their medicines in compliance packs. Some people had weekly or monthly compliance packs. A member of the team checked prescriptions for changes and sometimes the hospital sent a summary, or the doctor called following a hospital stay to advise the pharmacy about changes in medication. The pharmacy team members wore gloves when handling medicines and checked whether a medicine was suitable to be re-packaged. Sometimes a high-risk medicine such as alendronate was supplied in the compliance pack if it helped the person to

take to take it at the best time. But generally high-risk medicines were supplied separate to the pack. They did not provide a description to help people identify each tablet or capsule but they did supply patient information leaflets (PILs) for each medicine contained within the compliance packs. Members of the pharmacy team initialled the dispensing labels on medicines, so they knew which of them prepared a prescription. And they kept some prescriptions to one side 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 pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging. The dispensary was untidy in places which limited the amount of available workspace or storage. The pharmacy team checked the expiry dates of medicines a few times a year and the SI said it was part of the final check. 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 refrigerated between two and eight Celsius. The SI demonstrated how to take minimum and maximum fridge temperatures of the refrigerator which were recorded. The pharmacy stored CDs securely in line with safe custody requirements. The pharmacy kept obsolete medicines 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. Affected stock was quarantined and returned to the supplier. Keeping records of these actions was discussed.

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 one glass measure for use with liquids and a spare measure had been purchased in case of breakage as discussed during the previous visit. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. The pharmacy team disposed 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.