General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The French Pharmacy, 10 New Cavendish Street, London, W1G 8UL

Pharmacy reference: 9011483

Type of pharmacy: Internet / distance selling

Date of inspection: 02/06/2021

Pharmacy context

This pharmacy first opened in December 2020. It is located alongside other local shops in an affluent area of central London close to Marylebone High Street. It mainly sells beauty and wellbeing products which are also offered through its website www.thefrenchpharmacy.co.
It also dispenses private prescriptions and it sells some over-the-counter medicines. It does not provide any NHS services.

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	1.5	Standard not met	The pharmacy's insurance arrangements do not cover professional indemnity.
		1.6	Standard not met	The pharmacy does not adequately maintain the records it needs to by law. Responsible pharmacist logs and private records are incomplete. Original prescriptions are not always obtained and retained as they should be. And the pharmacy does not properly document supplies of unlicensed medicines.
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 not all met	4.3	Standard not met	The pharmacy does not source some of its medicines through appropriate channels.
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 always identify and manage risks as well as it could do when it undertakes new activities or services. It does not make sure it has appropriate professional indemnity insurance in place for the services it provides. And it does not accurately maintain the records it needs to by law. The pharmacy team members generally keep people's information safe and pharmacists understand their role in safeguarding vulnerable people.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs)based on trade association templates. These had been prepared by the part-time dispensing assistant. Some SOPs were not relevant to the current activities. Others were not tailored to the business, and SOPs were generally not embedded into practice. The superintendent pharmacist (SI) had approved them, but other team members had not read or signed those relevant to their role. This means team members might not always work effectively or understand what is expected of them.

Staff wore face masks when working and a screen had been installed on the counter to help with infection control in light of the covid pandemic. Team members were not routinely completing lateral flow tests as an extra safeguard to make sure they were infection free. Standard risk management processes had been put in place in relation to dispensing processes. Pharmacists initialled dispensing labels to show they were responsible for a supply. They were usually required to self-check, but they were not working under pressure and they could assemble medicines away from distractions. The pharmacist explained that the patient medication record (PMR) system had reporting tools for recording near misses and errors although they had not had occasion to use these. Any issues or concerns relating to the pharmacy services were communicated to the other regular pharmacist. There was no evidence that risks had been properly assessed prior to commencing some of the pharmacy's activities. For example, the implications of purchasing medicines from overseas had not been fully considered.

The pharmacy's complaints procedure was explained on the website but there was no information about this available in the pharmacy itself, so people visiting the pharmacy might not be aware of it. Business insurance was arranged with Sigma but the policy did not cover professional indemnity. The SI sought confirmation of this and took steps to obtain appropriate cover through Numark.

A responsible pharmacist (RP) notice was displayed next to the dispensary and was visible from the counter. The RP log was maintained electronically using the facility in the patient medication record system (PMR). Entries made each day identified the RP but the time the pharmacist ceased undertaking this responsibility was not recorded. Private prescription records were held electronically on the PMR system. A sample checked contained most of the relevant details although occasionally the prescriber's address was missing. Prescribers sometimes sent a copy of a prescription by email so the pharmacy could supply it straightaway, but the original prescription was not always provided. This meant the pharmacy could not retain the original prescription in accordance with the law. The pharmacy also supplied some unlicensed medicines on prescription, but it did not keep 'specials' records demonstrating how these medicines were sourced and supplied.

The pharmacy was registered with the Information Commissioner's Office. A privacy notice was included on the website, but it was not displayed in the pharmacy. Pharmacy team members had not completed formal training on the General Data Protection Regulation, but they understood what confidentiality meant and that people's personal details should not be disclosed. Confidential material was stored out of public view. A shredder was used to destroy confidential paperwork.

Both of the regular pharmacists had completed the Centre for Pharmacy Postgraduate Education safeguarding training, so they knew how to identify and escalate concerns. Other team members had not completed safeguarding training so they may not know what signs to look for and be less confident supporting vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload. Team members involved in selling medicines complete GPhC accredited training. But the pharmacy's approach to staff management and training is unstructured, which means team members may have gaps in their knowledge or miss opportunities to improve.

Inspector's evidence

At the time of the inspection, the pharmacist was working with a trainee medicines counter assistant and two temporary business exchange students. The exchange students mainly assembled online orders but occasionally helped on the counter. Footfall was low and the workload was manageable.

The pharmacy also employed a part-time dispenser and a second pharmacist who worked as the RP on the SI's days off. The team worked flexibly to cover any absences. Team members planned their holidays to make sure the pharmacy had enough staff cover. Lone working was not permitted.

. The dispenser had completed Buttercups training whilst working at another pharmacy. The trainee MCA was enrolled on a Buttercups course. But the pharmacy did not have a structured staff induction, training programme or review process

Team members worked under the constant supervision of the pharmacist. They communicated with each other openly. The SI worked several days each week at the pharmacy so team members could approach her if they had a concern. A whistleblowing policy was included in the staff handbook.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally suitable for the services that it provides. But the dispensary is cluttered and untidy which makes it harder for team members to work safely and effectively.

Inspector's evidence

The pharmacy was situated in a traditional retail unit arranged over two floors. The ground floor consisted of a retail area with a counter to the rear. A room next to the counter was used as a dispensary and office area. There was a staff toilet with handwashing facilities behind the counter.

The retail area was basically fitted with free standing units. It was reasonably well organised. The dispensary had a small amount of bench space, a cupboard and a couple of open shelves used to store medicines. It was cluttered and untidy.

Stairs from the retail area led to the basement which had two treatment rooms, a customer waiting area, additional storage cupboards and a toilet. The treatment rooms were occasionally rented out to for wellbeing services. One of the treatment rooms could usually be used for confidential conversations if needed, otherwise the pharmacist used a quiet part of the retail area out of earshot of other customers.

The pharmacy's website contained GPhC logo and information about the company including the superintendent's details. Only beauty and wellbeing products could be purchased via the website.

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

Summary findings

The pharmacy generally sources and supplies medicines in the right way. But it obtains a small amount of overseas licensed medicines from unauthorised suppliers which introduces a patient safety risk.

Inspector's evidence

The pharmacy was open seven days a week; Monday to Saturday 10am to 7pm, and Sunday 12pm to 5pm. People could contact the pharmacy by email or telephone, contact details were included on the website. The SI and some of the staff were French speaking.

The pharmacist supervised all supplies of conventional medicines. Prescriptions were usually received as walk-ins. The pharmacists usually assembled, checked and handed prescription medication out. Prescription interventions were not routinely recorded, so the pharmacist could not demonstrate when extra checks had been completed prior to making a supply. The pharmacist was able to identify high risk medicines and understood the risks of taking valproate in pregnancy.

The pharmacist was accredited to provide emergency hormonal contraception and short courses of antibiotics for uncomplicated urinary tract infections under patient group directions. The pharmacy was intending to offer a private flu vaccination service in the autumn.

The pharmacy dispensed a number of prescriptions written by doctors in the EU, predominantly France. These were commonly for French people who were living or working in the UK. The pharmacist explained she verified these prescriptions by contacting the prescriber directly if she had any concerns.

The pharmacy stocked a few French licensed medicines which it sourced directly from a pharmacy in France. The pharmacy did not have a Wholesalers Dealers Authorisation permitting the import of medicines from the EU. These medicines were occasionally used when dispensing prescriptions which specified a French licensed medicine, such as a branded oral contraceptive. A few French licensed OTC medicines were sourced from the same supplier. The pharmacist stated that some people preferred these to UK licensed products. The pharmacist explained how she made sure people were familiar with them and could understand the instructions when selling these medicines. They were kept in drawers behind the counter, so they were not on display. The pharmacist was unaware that only medicines licensed in the UK should be sold OTC, and she agreed to suspend sales of these products.

Other medicines were obtained from UK licensed wholesalers. OTC medicines were stored behind the counter so these could be supervised. Prescription medicines were stored in the dispensary. The pharmacy did not stock or supply any schedule 2 or 3 controlled drugs. Cold chain medicines were stored in a medical fridge. The fridge temperature was monitored and recorded to show it was within range. Dispensary stock was disorganised in places. No out of date medicines were found on the shelves. The pharmacist was familiar with the MHRA’s alerts and recalls process for defective medicines and medical devices. However, the pharmacy did not have a systematic way to make sure it received and actioned these, so they might be overlooked. The pharmacist agreed to subscribe to MHRA email alerts and make sure she could demonstrate these were received and actioned moving forward.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the appropriate equipment and facilities for the services that it provides.

Inspector's evidence

The pharmacist had access to the current British National Formularies. The internet could be used for research and if additional information was needed. There were cartons and counting equipment for dispensing purposes. Measures were plastic and not clearly marked as British standard approved, so the pharmacist agreed to replace these with calibrated measures obtained from a reputable supplier. The PMR system was password protected and computer screens were located out of public view.

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.