General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: MI Health Ltd, Office G002, Longcroft House, 2-8 Victoria Avenue, London, EC2M 4NS

Pharmacy reference: 9011648

Type of pharmacy: Closed

Date of inspection: 24/08/2023

Pharmacy context

The pharmacy is in an office block near Liverpool Street station in London. It offers onsite consultations with a pharmacist, and it prescribes medicines for a range of conditions such as acid reflux, asthma, altitude sickness, hair loss, erectile dysfunction, contraception and period delay. And it supplies medicines against private prescriptions. It provides travel vaccinations and medicines, and offers ear wax removal and blood testing services. The pharmacy's website can be found at www.myprivatechemist.com. The pharmacy 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	1.1	Standard not met	The pharmacy does not adequately identify and manage the risks associated with its prescribing service. It does not carry out adequate risk assessments for this service.
		1.2	Standard not met	The pharmacy does not sufficiently monitor the safety and quality of the various elements of its prescribing service. For example, by undertaking regular clinical audits.
		1.6	Standard not met	The pharmacy's private prescribing service consultation records do not contain all the relevant details. So, this makes it more difficult to understand the reason for the prescription and the clinical evidence available to the prescriber at the time.
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	N/A	N/A	N/A
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 adequately identify and manage the risks associated with all its services, particularly its prescribing service. The risk assessment for its prescribing service does not cover all the potential risks of the service. And it does not always have written procedures available for staff to follow. The pharmacy does not monitor the safety and quality of its prescribing service, for example by doing regular clinical audits. And its consultation notes for this service do not always contain the relevant details. However, the pharmacy largely keeps its records up to date and accurate. It protects people's personal information well. And people can provide feedback about its services. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) were not all available during the inspection. Which could make it harder for the pharmacy team to know what the right procedures are. Following the inspection, the superintendent pharmacist (SI) sent a sample of the SOPs and risk assessments to the inspector. The independent prescribing for minor ailments SOP was dated as being prepared on 11 September 2023 (after the inspection). It was largely copied from published guidance and was not sufficiently tailored to the pharmacy's prescribing service. For example, it failed to outline all of the conditions the prescribing service could treat, and it did not contain information on prescribing medicines which had were initially authorised by a different prescriber. Also the section on safeguarding was not tailored to the prescribing service or the conditions which could be seen. The risk assessment was dated 24 August 2023 which was the date of the inspection. It did not contain information on risks associated with the medicines prescribed by the service. Such as, the additional safeguards needed when prescribing medicines which require ongoing monitoring, for example medicines used to treat asthma, or antimicrobials for infections. And there was no consideration of the transcribing service in the risk assessment, and the risks associated with providing this service. The SI stated that the pharmacy did not prescribe higher-risk medicines, but the risk assessment did not define what was considered a higher-risk medicine. The pharmacy had not undertaken any audits on the prescribing service. The evidence provided by the SI did not demonstrate that there was sufficient oversight of prescribing activity at the time of the inspection. The risk assessment for the prescribing service referred to a medical professional who was available to review complex cases. But there was no documentation of this having occurred. And as there were no audits of the prescribing service this made it harder for the pharmacy to show appropriate evidence and guidelines were followed.

The SI said that there had not been any near misses, where a dispensing mistake was identified before the medicine had reached a person. And he said that this was likely down to the low number of items dispensed. He said that he would highlight any near misses with the team member involved at the time of the incident. If the checking pharmacist had also dispensed the medicine, they would review their own dispensing and checking processes. A record was available for recording any near misses and the SI said that this would be reviewed for patterns. The SI said he was not aware of any dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He said that he would report any dispensing errors on the National Reporting and Learning System and undertake a root cause analysis.

Workspace in the pharmacy was free from clutter. The team members signed the dispensing label when

they dispensed and checked each item to show who had completed these tasks. Patients were asked to wait in the reception area while dispensing tasks are undertaken. The SI said that prescriptions written by him were dispensed and checked by another pharmacist. The pharmacist said that she took a mental break between dispensing and checking the medicines. The SI said that information about how to take the medicines was provided to the patient during the consultation. And when the medicines were handed out, the pharmacist confirmed the person's name and address.

The pharmacy employed only pharmacists and it would remain closed if there was no pharmacist available, or if the pharmacist working on the day was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The records about private prescriptions dispensed were completed correctly. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. Following the inspection, the pharmacy provided consultation notes for a sample of prescriptions written by the SI. But from the notes, it was unclear how differential diagnoses were excluded based on the documentation supplied. And the consultation notes did not provide details about any advice given to the person if their symptoms worsened. Two consultation records were reviewed for people who were diagnosed and treated with antibiotics for pharyngitis (a sore throat). The records stated that these people had tested negative for presence of a main causative bacteria. But there was no explanation why the prescriber felt antibiotics were still required. And the records did not outline how the prescriber excluded other potential causes of sore throat in these people. Key information to advise when people should seek advice if their condition worsened was not documented in the consultation notes. The SI sent amended versions of these consultation records at a later date, so this made it harder to show that the consultation notes were made contemporaneously.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Team members had completed training about protecting people’s personal information.

The SI said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy’s website.

The SI and pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. He could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the relevant authority. He said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. They do some ongoing training to help keep their knowledge and skills up to date. And they can discuss any concerns that they might have.

Inspector's evidence

There were two pharmacists working during the inspection. One was a pharmacist independent prescriber and was also the SI. The SI said that he was able to manage the workload for the prescribing service. The other pharmacist was usually the RP and additional cover was provided when needed by a third pharmacist who was also one of the directors.

The SI and RP were aware of the continuing professional development requirement for professional revalidation. The SI said that he ensured that all team members undertook the necessary training before a new service was implemented. He explained that he had specialised in minor ailments and only prescribed within his scope of practice. Following the inspection, The SI provided a CPPE certificate on Minor Ailments dated 2017, and a consultation skills certificate dated October 2023, along with confirmation of completion of their prescribing course. The RP had completed training for the phlebotomy and ear micro suctioning services recently. The RP said that she could complete training during the day when the pharmacy was quiet.

The pharmacists said that they regularly read pharmacy-related magazines and online articles, and they discussed ones relevant to the pharmacy's services. They said that there were informal meetings, and they discussed any issues as they arose. And they felt able to make professional decisions. Targets were not set for team members.

The RP said that she had recently had a discussion with the SI about which medicines the pharmacy should stock. Following her suggestions, the pharmacy had amended its stock lists to reflect the suggested changes. The RP said that she had informal ongoing performance reviews with the SI. She had asked to be enrolled on an additional phlebotomy course so that she could draw blood from the back of the hand. And this had been agreed with the SI.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout and this presented a professional image. Medicines were kept on shelves behind the pharmacist’s desk. She explained that she would not leave people alone in the pharmacy. And the door locked automatically when it was closed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was a bench and chairs in the pharmacy for people to use. And the room was accessible to wheelchair users. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from outside the room. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

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

Summary findings

As described under Principle 1, there are issues with how the pharmacy manages its prescribing service. However, it generally manages its other services appropriately. It pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised on the pharmacy's website. And people could book an appointment via the website. There were staff on the reception desk for the building during the pharmacy's opening hours. People accessing the pharmacy were asked to wait in the reception area of the building until a member of the pharmacy team was free to escort them.

The pharmacy prescribed treatments for a range of medical conditions, including acid reflux, asthma, altitude sickness, hair loss, erectile dysfunction, contraception, and period delay. The SI said that the pharmacy did not make supplies of higher-risk medicines and people would be referred to their GP if they needed these. But there was no documentation about how the pharmacy assessed certain medicines as higher-risk. The RP said that the pharmacy sold very few over-the-counter medicines, and these were usually sold during a consultation. People had telephone consultations if they wanted advice about travel and were invited for a face-to-face consultation if they needed medicines or vaccinations. The SI said that vaccinations were provided against Patient Group Directions and that he had undertaken the required training for these.

The SI explained that the pharmacy offered a service to prescribe medicines which were initially authorised by a different prescriber. He said that he spoke with the original prescriber before transcribing to ensure that the supply was appropriate. And only for medicines where the person had been taking then on a long-term basis. The risks associated with this service were not documented in the risk assessment for the prescribing service. And the SOP for the prescribing service did not refer to this service either.

The SI explained the processes for the prescribing service and said that people were asked to consent for the details of the consultation to be sent to their regular prescriber, such as their GP. But this was optional. This meant there was a risk that people who were prescribed medicines which require ongoing monitoring and management may not be followed up by their regular prescriber. For example, the pharmacy offered to prescribe medicines for asthma on the pharmacy's website. This is a condition which required ongoing monitoring, so information should be shared between professionals who prescribe for people with this condition. And this had not been adequately considered in the risk assessment. The SI said that he recorded when prescriptions were declined and signposted people to their regular prescriber. If a prescription was written, this was handed to the person, and they were informed that they could use take it to a pharmacy of their choice. The SI said that people usually took their prescription elsewhere as the pharmacy did not stock many medicines. But he did offer for the pharmacy to order the medicines in. He also mentioned that it would be rare for him to dispense a prescription that he had written as there was usually another pharmacist available, or the person was

asked to return the following day to collect their medicine.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the MHRA and suppliers. The SI explained the action the pharmacy took in response to any alerts or recalls. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Fridge temperatures were checked twice a day and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

The pharmacy did not offer a delivery service, but it did offer a blood testing service. The pharmacy used a laboratory which collected samples from the pharmacy via courier for testing. Results were sent directly to the person and the pharmacy received a copy if the person gave consent. There was a phlebotomy service SOP available for team members to follow.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had a glass cylinder for measuring liquids but not one for volumes less than ten millilitres. The SI said that he would order a suitable measure. Up-to-date reference sources were available in the pharmacy and online. The SI said that the blood pressure monitor was replaced in line with the manufacturer's guidance. The weighing scales and the shredder were in good working order. And the phone in the pharmacy was portable so it could be taken to a more private area where needed.

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.