General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Private Pharmacy Group Ltd, Unit 2, Premier Park Road, London, NW10 7NZ

Pharmacy reference: 9011818

Type of pharmacy: Closed

Date of inspection: 23/05/2023

Pharmacy context

The pharmacy is in a business park in northwest London. It dispenses mainly private prescriptions and some NHS prescriptions. It has an NHS distance selling contract and is closed to the general public. This was the first inspection after the pharmacy had been approved for registration.

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	1.1	Good practice	The pharmacy assesses risk before introducing changes to services. Risk assessments are reviewed to maintain safe services.
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’s working practices are safe and effective. It assesses the risks before new services are introduced. Pharmacy team members follow suitable written procedures which tell them how to manage risks so they work safely. They keep the records they need to by law and they regularly count the pharmacy’s stock to check the controlled drugs records are correct. The pharmacy's team members keep people's private information safe. They understand their role in protecting the welfare of vulnerable people.

Inspector's evidence

The majority of prescriptions processed by the pharmacy were for medicines to treat attention deficit hyperactivity disorder (ADHD). The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded and reviewed near misses to identify trends in types of error although the responsible pharmacist (RP) reported that errors were often random. They discussed the mistakes they made to learn and reduce the chances of them happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as different strengths of Amfexa, were generally separated from each other in the dispensary. The pharmacy submitted an annual analysis of incident data into NHS England’s ‘learning from patient safety events’ service.

The pharmacy received prescriptions by post which was opened by two team members. They checked the credentials of any new prescribers. The pharmacy had access to a shared portal between the doctor, patient and pharmacy. The team members scanned the barcode on each FP10PCD prescription to let the portal know the pharmacy had received the prescription. The portal messaged the patient when it had received their prescription. The portal had information such as the diagnosis and patient contact details. If necessary, the pharmacist could contact the patient in the event of an incident or to provide counselling information. The RP completed the clinical screen of the prescription at the beginning of the dispensing process. Members of the pharmacy team responsible for making up people’s prescriptions used baskets to separate each person’s medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking medicines. Team members moved the baskets in the direction of the dispensary workflow via conveyor belts. The pharmacy had reviewed and enhanced checking procedures to ensure patient details printed on the prescriptions, documents and labels all matched before bagging and sealing medicines for delivery. It checked if there was more than one package for one person pre-delivery. The RP had introduced a new role of accuracy checking dispenser (ACD) to help manage checking in the dispensing procedure. The pharmacy kept owing medicines to a minimum and supplied emergency cards with additional information about high-risk medicines. The team checked interactions between medicines prescribed for the same person and intervention notes were recorded in case of future problems.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed in the last year. 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. The ACD’s trained in an SOP tailored to their amended role in the dispensing and checking process. The pharmacy had a complaints procedure and people could leave feedback about the pharmacy via an annual patient survey. The pharmacy completed various risk assessments to identify and manage things that could go wrong such as workflow, staffing, business continuity, medicines shortages, delivery, introducing the

role of ACD and having a second pharmacist at certain times. As part of a business continuity plan, the pharmacy had an SOP for the team members to follow if the locum pharmacist did not arrive. The RP regularly monitored the quality of services by conducting audits. These included NHS audits such as the valproate audit and controlled drug (CD) audits to check the amount of stock held by the pharmacy matched what was recorded in the register. The RP monitored numbers of prescriptions dispensed in a timeframe, uniformity of process and used his findings to estimate capacity.

The pharmacy displayed a notice that told people who the RP was 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. It kept records of patient consent for people who used their services. The pharmacy maintained a CD register which was only accessed by certain team members. The RP and the ACD audited CDs regularly and CD invoices were retained and checked before generating a report. A random check of the actual stock of a CD matched the recorded amount. The pharmacy booked CD packages out of the CD register for delivery. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. It recorded the private prescriptions it supplied. And these were in order.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice on its website that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy sent a link to people to make secure payments. It's team members had signed confidentiality clauses and trained in general data protection regulation (GDPR). So with consent they could access the portal and people's information and deal with queries such as requesting a new prescription. They made sure people's personal information was disposed of securely. The pharmacy had a safeguarding SOP. And the RP had completed a level 2 safeguarding training course. Members of the pharmacy team 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 team members are actively encouraged to develop their skills and knowledge. They work well together and manage the workload. They feel comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist, and a second part-time pharmacist who helped with checking prescriptions, four full-time trained or trainee accredited accuracy checking dispensers (ACDs) and a person who helped with packing up at the end of each day who had completed in-house training. The pharmacy was planning to recruit a second full-time pharmacist. Pharmacists would train as independent prescribers.

Members of the pharmacy team were provided training via a training platform. ACDs had learning events and had to check a set number of items in a certain time as evidence. They were allocated protected learning time which fitted in with the pharmacy's workflow and training records were maintained. ACDs had set aside time with the RP to discuss queries and progress with training. There were appraisals to monitor the team members' role and development needs. They could ask the RP questions at regular team meetings. And discuss issues in the dispensary such as predicted workflow changes or the pharmacy switching to a new carrier. Team members were comfortable about making suggestions on how to improve the pharmacy and its services and had suggested modifying the bagging and checking procedures to minimise errors. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of pharmacy services. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a large, spacious dispensary and an office. The pharmacy did not have a consultation room but it did not have any face-to-face contact with people but people could message the pharmacy via the portal. The dispensary was set up to accommodate the pharmacy workflow with conveyor belts and designated dispensing or checking areas. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It gets its medicines from reputable suppliers so they are fit for purpose. The pharmacy's team members make sure medicines are stored securely and they are safe to use. They take the right action if any medicines or devices need to be returned to the suppliers. The pharmacy maintains appropriate audit trails to show that medicines are delivered to the right people.

Inspector's evidence

The pharmacy was closed to the general public, so it did not have face-to-face contact with people who used its services. But the pharmacy had access to a shared portal between the doctor, patient and pharmacy. If the RP identified an error while clinically checking the prescription, a replacement prescription could be arranged and obtained for the next working day. The portal had information such as the diagnosis and patient contact details. So the pharmacist could contact the patient in the event of an incident or with counselling information. People could access which mental healthcare provider they were referred to via 'Right to Choose' and after an interval transfer to shared care. The doctors involved in their care could sign the person up and send their prescriptions to the pharmacy.

The pharmacy team members could print large font labels to make them easier to read. And they noted counselling given to people to help them take their medicines in the best way. They could refer to the person's treatment plan on the portal and complete any information such as therapeutic monitoring. If needed, people were signposted to an organisation such as Psychiatry UK. The pharmacy had a protocol for dealing with medicine shortages to help make sure people did not go without their treatment. The RP was aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed.

The pharmacy provided a delivery service to people as they were unable to attend its premises in person. It packed medicines in strong, plain packaging and having checked to ensure patient details printed on the prescriptions, documents and labels all matched before bagging and sealing medicines for delivery. It checked if there was more than one package for one person pre-delivery. The pharmacy did not dispense and deliver any items requiring refrigeration. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The courier operated a trackable service using a unique PIN code system. And CD deliveries must be delivered within a time limit.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices within their original manufacturer's packaging. The dispensary was tidy. The pharmacy team checked the expiry dates of medicines when it dispensed them and every two to three months. And it generally recorded when it had done a date-check. And it mostly stored its CDs, securely in line with safe custody requirements. The pharmacy had procedures for handling obsolete medicines which were kept separate from stock or were placed in one of its pharmaceutical waste bins. It had a procedure for dealing with alerts and recalls about medicines and medical devices. The RP described the actions they took and demonstrated what records they kept 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 online reference sources for information and guidance. Its 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. And its team members used 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.