General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacyforce, 101 Whitechapel Road, (Lower Ground Floor), London, E1 1DT

Pharmacy reference: 9012042

Type of pharmacy: Internet / distance selling

Date of inspection: 10/12/2024

Pharmacy context

This pharmacy is located on a high street in Whitechapel, London. It provides NHS services at a distance including dispensing prescriptions, the New Medicine Service (NMS), and six of the Pharmacy First services. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home. And it provides a delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 adequately manages the risks associated with its services. It uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. People using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services.

Inspector's evidence

Standard operating procedures (SOPs) were available in the dispensary for the team to refer to if required. They had been written in 2023 and the SI was in the process of updating them, team members confirmed they had read them. When asked, team members were clear about their roles and knew when to refer to the responsible pharmacist (RP). They knew what activities could and could not be done in the absence of an RP. The superintendent pharmacist (SI) was the RP on the day of the inspection, and the RP notice was correct and visible. The RP record was held electronically and was mostly complete. The pharmacy did not hold stock of controlled drugs (CDs) requiring safe storage. Documentation for unlicenced medicines supplied were well maintained and one of the trainee pharmacy technicians said that they did not often give emergency supplies, due to the NHS 111 emergency prescriptions service. Records for private prescriptions did not always contain the correct prescriber information, this may mean that this information is harder to find out if there was a query. There were some prescriptions that had been issued by the SI, with the last one seen dated September 2024. The pharmacy did not have a prescribing policy or risk assessment in place for a prescribing service, however the SI explained that this was not a service that the pharmacy advertised, and they had since stopped offering the service.

A risk assessment was in place for offering services at a distance and addressed some risks and mitigation associated with this including data security, medication deliveries and limited physical examination for offering advanced NHS services. The pharmacy had also completed some audits for the services offered including pharmacist interventions, management of repeat prescriptions and provision of steroid cards where appropriate. The audits contained actionable points for service improvement.

The pharmacy had logs available to record dispensing mistakes that were identified before reaching a person (near misses), however the most recent completed log could not be located at the time of inspection. Team members explained that informal discussions with the pharmacist were had at the time the mistake was made to address any feedback and generate ideas to prevent future mistakes. One of the trainee technicians showed that a few medications with different strengths or those that looked alike, had been separated in the dispensary. This demonstrated some action taken to minimise mistakes. The SI said that the pharmacy had not experienced a dispensing mistake which had reached the person (dispensing error). But explained that staff escalated any issues to the SI, and described the actions they would take, including speaking to the person who was impacted by the error, retrieving medications to make any necessary corrections. And reporting the error to the person's GP where required and discussing with the team members involved to establish learning and prevention. There was an SOP available for dealing with dispensing errors which included reference to the national reporting system. However, this listed the old reporting system. The SI gave assurances that the newer Learn from patient safety events (LFPSE) service details would be included in the SOP update to ensure any errors were reported to the national system.

Current indemnity insurance was in place. Feedback or complaints from people using the pharmacy's services could be received, in writing, via telephone or email and through online review sites. If a complaint was received, team members could escalate issues to the SI, and there was a complaints procedure they could refer to. If people wanted to speak with the SI a video link could be sent to them.

The computer was password protected meaning that confidential electronic information was stored securely, and confidential paper waste was shredded on-site. Team members had completed data protection training and an information governance policy was in place for reference. They understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. Team members had completed training and were aware how to refer to safeguarding authorities if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open environment.

Inspector's evidence

The team present during the inspection consisted of the SI, and two trainee pharmacy technicians. Team members were enrolled on accredited courses. The SI explained that locum staff were employed for business continuity when required to cover any pharmacist absences. The team was up to date with dispensing prescriptions with no backlog of workload. And team members were able to demonstrate an awareness of medicines with the potential for misuse. They knew questions to ask when providing advice and when to refer to the pharmacist.

The SI said they felt comfortable in using their professional judgement when decision making. And they said that they attended a forum once a month, led by the local NHS integrated care board to keep up to date with clinical learning. There was no structured process for ongoing development of the trainee technicians outside of their accredited courses. However, they were able to access online training resources, they explained that they usually completed these outside of work hours due to lack of computer access onsite. But said that any learning that required clarification or further information was discussed with the SI in work hours.

Team members were assigned areas of responsibility including dispensing, clinical activities, and relationships with stakeholders. They had individual appraisals and had the opportunity to progress through different accredited courses. When asked, they felt able to raise concerns with the SI and described working openly as a team. They said that any concerns and ideas were usually discussed informally as a group. The team gave examples of changes that had been made in response to their feedback. This included storing items that were most frequently dispensed in a designated area with ease of access to help workflow, and requesting a larger fridge to appropriately store stock due to the increase in number of items dispensed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it has adequate space for providing its services safely. The pharmacy premises are also safe, secure, and appropriately maintained.

Inspector's evidence

The pharmacy was in the basement of a currency exchange shop down a set of stairs and was not physically accessible to the public. On entering the pharmacy there was a dispensing bench in the centre and a labelling station with a computer to the side. The dispensary had suitable lighting, and the temperature was appropriate for the storage of medicines. A clean sink was available in the dispensary for preparing medicines. At the back of the dispensary there was a small office where the pharmacist held virtual or telephone consultations. This had a sink available for handwashing. A staff toilet with separate handwashing facilities was also available at the rear of the premises. Team members had a cleaning rota to maintain the pharmacy.

The pharmacy’s website contained details about the superintendent pharmacist and the pharmacy’s location and contact details. Links were available to access the pharmacy’s privacy policy and terms and conditions. The terms and conditions clearly specified the third-party company who supplied medicines purchased through the website. And there was a ‘feedback and complaints’ page. People could buy general sales list medicines through the website which was managed by a third-party company. Information was available about each of the services that the pharmacy offered.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy suitably manages its healthcare services. It sources its medicines from licenced suppliers and stores them appropriately. Team members take the right actions to take in response to safety alerts and recalls, to ensure medicines and medical devices are fit for purpose.

Inspector's evidence

The pharmacy offered services by video consultation only, and signposted people to other nearby pharmacies where necessary. Large-print labels were available on request, and all team members were multi-lingual, which helped them to better communicate with the people in the surrounding area. The pharmacy offered six of the Pharmacy First services under patient group directions (PGDs) and these were available on the SI's laptop for reference. The pharmacy mainly received referrals for pharmacy first services from NHS 111, but people could self-refer if required. The SI said that if a person did not meet the criteria for treatment, or if they could not be appropriately assessed via video consultation, then they signposted people to pharmacies that offered a face-to-face service or their GP.

Medicines were sourced from licensed suppliers. Expiry date checks were carried out routinely and a current date checking matrix was seen during the inspection. A random spot check of stock revealed no expired medicines, and stickers were used to mark any short-dated items. A medicines waste bin was available for disposing of medications. Temperature records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius. The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's email and patient medicines record (PMR) system. Emails were checked by team members daily and some of the alerts were printed and kept in a folder. The SI gave assurances that an audit trail for all actioned alerts would be maintained going forward.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to keep items for different people separate. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. The process was managed by allocating people into designated weeks. The pharmacy used this system to organise ordering repeat prescriptions for people, to help ensure they were ordered in a timely manner for dispensing. One of the trainee pharmacy technicians said that they contacted the surgery if there are any items missed or any changes made to a person's regular prescription, and these were documented via email. Documented examples for this were seen during the inspection. Medicine warnings were printed on the backing sheets inside of the packs. Descriptions of each of the medicines was also printed on the sheets and patient information leaflets were provided with each supply.

The pharmacy offered a delivery service and used a local courier for this. All deliveries were made within the pharmacy opening hours and drivers signed for receipt of the deliveries to maintain an audit trail. The pharmacy telephoned people prior to delivery where possible and medicines were returned to the pharmacy if people were not home. The SI explained that staff members occasionally delivered urgent prescriptions for people who lived locally, or they released prescriptions back to the spine for people to collect elsewhere if they could not deliver.

When asked, team members were aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. The importance of undertaking individual risk assessments if valproate was not dispensed in the original manufacturer's pack was discussed with the SI who gave assurances that this would be completed where appropriate if they had people requiring valproate in their compliance packs. Prescriptions for other higher-risk medicines were highlighted by the PMR system when dispensing and the SI contacted these people for counselling over the telephone. One of the trainee pharmacy technicians showed that some higher-risk medications were separated in the dispensary to ensure double checks were made when dispensing these.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment to provide its services safely. And it protects people's privacy when using its equipment.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids and clean triangle tablet counters were available for dispensing loose medication. A separate triangle counter was available for certain substances that were marked to avoid cross-contamination. Gloves and a roller were available for dispensing and sealing compliance packs. The SI explained that they hoped to expand the pharmacy's services to include face-to-face consultations and so a new blood pressure monitor, glucose meter and thermometer were available in the pharmacy. A portable telephone enabled the team to ensure conversations were kept private were necessary. All team members had their own NHS smartcards for accessing electronic prescriptions.

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.