General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmulous, Argent House, 175 Hook Rise South, Surbiton, KT6 7LD

Pharmacy reference: 9012252

Type of pharmacy: Internet / distance selling

Date of inspection: 23/04/2024

Pharmacy context

This is a closed pharmacy in an office building just off the A3 between Chessington and Surbiton. It is not open to the public and mostly dispenses private prescriptions it receives in the post, which it then delivers. The pharmacy also offers a travel vaccination service.

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 up-to-date written instructions which tell its team members how to complete their tasks safely. It adequately assesses the risks involved in providing its services remotely and has suitable insurance in place to protect people if something should go wrong. The pharmacy keeps appropriate records of what it does. It satisfactorily manages and protects people's confidential information, and it tells them how their information will be used. Team members also understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date Standard Operating Procedures (SOPs) in place to help the pharmacy's team members complete their tasks safely and effectively. The SOPs had been developed in October 2023 and were next due for review in October 2025. There were signature sheets signed by the responsible pharmacist (RP) to show that they would follow them. The RP pointed out that any new recruits would also have to read and sign the SOPs.

There was a daily near-miss record sheet available at the main workstation. It contained no entries as the pharmacy had only been open a short time, had dispensed very few prescriptions and had no incidents to record. The RP explained how he would review them monthly to identify trends or patterns as that was what he had done in a previous role. The RP was aware of 'Look Alike Sound Alike' (LASA) drugs and had organised the stock in categories such as their therapeutic areas to minimise the risk of selecting the wrong product.

The RP confirmed that he would ensure any new recruits would be made aware of what they could and could not do in the absence of the responsible pharmacist. The RP notice was correct and clearly displayed. All the entries examined in the paper RP record correctly recorded the date and time the RP's responsibilities commenced and ceased.

People could give their feedback about the pharmacy's services either verbally or via its website. The RP sent people a link to their Google review page with each prescription they dispensed. The feedback to date had been positive with nothing the pharmacy had to act upon. There was a plan so they could maintain the pharmacy's services in the event of an unforeseen emergency. Phone lines could easily be diverted if the building was inaccessible for any reason. There was also a generator to maintain the electricity supply in the event of a power cut. There was a certificate of professional indemnity and public liability insurance which was valid until the end of November 2024.

Private prescription records were kept electronically and those checked were complete with the required details. The patient medication record (PMR) system used for this appeared to have defaulted to 'NA' for all the prescribers' addresses although the RP was able to show those details elsewhere. Upon reflection he agreed to contact the PMR supplier to ensure the full details were displayed in the record. The pharmacy didn't dispense any controlled drugs (CDs) so there were no records to examine. The pharmacy hadn't needed to order any unlicensed medicines ('specials') but the RP was aware of the additional records they would need to keep if they did order any. Prescriptions were usually emailed or faxed to the pharmacy before the original was posted to it. All dispensing labels were initialled twice, once when the RP initially assembled the prescription, and then a second time for an

accuracy check when the hard copy of the prescription had been received. He explained that this was often the following day so allowed for a break in between the two activities. There was a risk assessment which described this process and how it mitigated the risks involved when only one person was dispensing and then checking their own work. Following a brief discussion, the RP agreed to set out the risks in more detail so that it was clearer how each risk was managed. There were also risk assessments available to cover the dispensing and administration of vaccines, making multiple supplies of medicines to the same address and the supply of medicines to people under 18.

A number of private prescriptions were examined, five of which were found to be vaccines prescribed and administered by the RP. There were some notes for each consultation, with some basic history, checks for allergies, red flags and safety netting. But they were stored loosely with the prescriptions, so he was advised to set up an organised filing system with detailed consultation notes if he was planning to offer more prescribing services.

The RP was able to demonstrate an understanding of data protection and provided examples of how they protected people's confidentiality. Confidential waste was kept separate from general waste and shredded onsite. There was a certificate to show that the pharmacy had registered with the Information Commissioners Office (ICO). There was a privacy notice on the pharmacy's website.

There were safeguarding procedures in place for both adults and children. The RP had contacted the safeguarding lead at the local council to obtain the necessary contact details for both adults and children. The RP had completed level 3 safeguarding and knew how to contact the relevant authorities. He was also signposted to the NHS Safeguarding app as a useful additional resource.

Principle 2 - Staffing ✔ Standards met

Summary findings

The sole team member has a satisfactory understanding of their role and how they can help people with the medicines they supply remotely. They are also suitably aware of the risks involved in selling some medicines and know how to respond appropriately. The pharmacy has enough staff to manage most of its current workload safely.

Inspector's evidence

There was just the RP on duty as there hadn't been any need to recruit additional staff. The RP confirmed that the staffing levels would be reviewed as the business grew or when new services were introduced.

There were certificates showing the training course completed by the RP. These included Level 3 safeguarding from e-Learning for Health (e-LfH), General Data Protection Regulation (GDPR) training, and recognising anaphylaxis training. The RP explained that he was also completing a PhD and was currently researching how pharmacists respond to drug shortages. He explained that he had been trained at a vaccination clinic where he previously worked. His initial scope of practice was minor ailments but had since been extended to vaccinations. He was aware of the Royal Pharmaceutical Society (RPS) guidance on extending scope of practice. He had a peer group of colleagues with whom he could discuss professional matters. He was advised to consider making arrangements for peer reviews of his prescribing practice and also to implement regular clinical audits before extending the prescribing service.

The RP was aware of which medicines may be liable to misuse and the risks involved in supplying them remotely, so didn't have any plans to start doing so. He did have someone else available to discuss any concerns with and to help generate solutions to any problems which may arise. There were no targets in place although the RP was continually looking for opportunities to grow the business which didn't compromise his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a professional, safe and secure environment for people to receive the pharmacy's services in person. The pharmacy's website contains the information it should so that people can check that it is appropriately registered.

Inspector's evidence

The pharmacy's premises were a room within a small office block. There was a computer terminal for the patient medication record (PMR) system and workbenches for assembling prescriptions. The PMR system was password protected so could only be accessed by the RP. There was a shelving unit in the opposite wall for storing stock and a second one for paperwork. The premises were very clean, tidy and well organised. The pharmacy had access to toilet facilities elsewhere in the building. It could also book other rooms if required. The temperature in the pharmacy was maintained at a comfortable level by an air-conditioning system and was suitable for the storage of medicines. The premises were secure from unauthorised access. People wanting to visit the pharmacy had to use an intercom to let the pharmacy know they were there before being allowed in.

The pharmacy's website contains the required information, including registration details of the superintendent pharmacist and of the premises themselves. The RP, who was also the owner of the company and superintendent pharmacist, confirmed that he had read and understood the General Pharmaceutical Council (GPhC) guidance on providing services at a distance. The RP described his plans to expand the range of services offered and how he would be updating the website accordingly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its limited range of services easily accessible to people, both locally and online. It keeps satisfactory records of the services it provides. It makes the necessary checks to make sure people are who they say they are, and that they understand how to take their medicines safely. The pharmacy has suitable processes in place so that the medicines it supplies are safe for people to take.

Inspector's evidence

The pharmacy was currently providing a limited range of services which it highlighted on its website and by word of mouth locally. There were controls in place to help reduce the risk of errors, such as using baskets to keep individual prescriptions separate. Medicines were generally ordered upon receipt of an emailed or faxed prescription. Once the medicines arrived from the wholesaler, the prescription was assembled and the label initialled to show who had completed this step of the process. The assembled items were kept in a basket with the copy of the prescription until the original arrived in the post, usually the following day. Once the original prescription had arrived, the items were checked for accuracy and the label initialled again to complete the audit trail. The RP explained that as he checked his own work, the delay between labelling and checking helped ensure he was looking with a fresh pair of eyes and less likely to overlook any discrepancy. Once completed, the medicines were then either delivered by the RP if local, or sent by Royal Mail using their tracked service for prescriptions. There was a file containing details of the deliveries. The RP called people before delivering their prescriptions to provide advice on taking their medicines and to let them know when to expect the delivery. The pharmacy hadn’t yet delivered any controlled drugs and had no plans to do so.

The RP was aware of the risks involved in dispensing valproates to people who could become pregnant, and the need to check whether they had long-term contraception in place. They were also aware of the recently updated requirement to dispense valproates in the manufacturer’s original packaging, and to avoid covering any of the warnings with their dispensing label. The pharmacy didn’t currently supply any valproates to people in the at-risk group but the RP was reminded of the need to record each intervention on the PMR should the need arise. They were signposted to the MHRA website for further details. They were also aware of the need to avoid handling cytotoxic medicines and were reminded of the need to check whether people had had a recent blood test. The team also acknowledged the need to ask about blood tests for other high-risk medicines such as lithium. And again, to record each intervention on the PMR.

Medicines, including any unlicensed specials that may be needed, were obtained from recognised licensed pharmaceutical wholesalers. Fridge temperatures were recorded daily and seen to be within the correct temperature range. There was a small selection of medicines in stock which were kept in manufacturers’ original packs. There was a clearly laid out chart for staff to use when completing date checks on their stock. The RP was aware of the risk of items going out of date while turnover was still very low.

The pharmacy received drug alerts and recalls from the MHRA via email. There was a record of those alerts recently received, annotated with the actions taken. The RP was signposted to the NHS Central Alerting System (www.cas.mhra.gov.uk) as a useful additional resource to help ensure he didn’t miss any alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has most of the necessary equipment for the range of services it provides, and it makes sure that it is suitably maintained. The pharmacy keeps people's private information safe.

Inspector's evidence

The pharmacy had some crown-stamped measures, but only had a plastic syringe instead of a small measure. When this was pointed out the RP agreed to obtain a properly calibrated small measure. There was a large glass-fronted medical fridge which was still in its warranty period. There was a small shredder for disposing of confidential waste. There was also a trolley containing the necessary equipment and in-date anaphylaxis kits for administering vaccines.

All computers were positioned so that they were not visible to anyone visiting the pharmacy. They were password protected. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF online.

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.