General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Signature Pharmacy, Unit 9, Concord Business Centre, Concord Road, London, W3 0TJ

Pharmacy reference: 9012267

Type of pharmacy: Internet

Date of inspection: 12/06/2024

Pharmacy context

This is an independently owned pharmacy. The pharmacy is currently closed to the public and offers its services over the internet only. It does this through its website https://www.signaturepharmacy.co.uk. It is in an industrial unit, in a modern industrial estate near Acton town centre. It mainly dispenses private prescriptions. But it can also dispense electronic NHS prescriptions. And it delivers medicines to people.

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 suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy properly identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy mainly dispensed and supplied medicines from private electronic prescriptions. And it received its private prescriptions from several different independent prescribing services through its custom bult prescription platforms. But it also supplied medicines for a small number of NHS prescriptions. The pharmacy had risk assessed its services. And it had introduced a risk register which the superintendent pharmacist (SI) reviewed regularly. Since opening in 2016 the pharmacy's prescription numbers had increased. And so, the pharmacy had recently relocated to these larger premises. The SI had also recruited additional team members to manage the increased workload. This included a full-time responsible pharmacist (RP). The pharmacy used a highly automated barcode recognition system which team members used for checking in and picking medicines. But the pharmacy recognised that there could still be a risk of mistakes when a part pack was dispensed. And so, it kept all its split packs separate from its full packs. And this had helped to reduce the incidence of quantity errors. The SI recalled how the system had allocated a prescription to the wrong person. But due to the system's bar code cross checking process, the error had been picked up when the person's details had not matched the details on the packing label allocated to it. The SI raised this as a system error with the software provider and rectified it. The RP said she reported errors that occurred via an internal reporting system. She also recorded them on an internal note function visible to other team members. And discussed the errors in the team meeting for shared learning. She knew to report CD related incidents to the CDAO.

Team members discussed every incident, including their near-miss mistakes as soon as they were discovered. And they recorded them electronically. They also discussed them within the larger team during its regular team meetings.The RP described how she generally highlighted and discussed 'near misses' and errors as soon as possible with the staff member concerned to help prevent the same mistakes from happening again. The team did not appear to make many mistakes. But when it did, it discussed them. While it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not fully capture the detail of what team members had learned or how they would improve. The RP, SI and inspector discussed the importance of recording what the team had learned from its near misses and any actions arising from them. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help prevent similar mistakes in future. Team members reviewed and reflected on their mistakes regularly to learn and improve.

The team worked under the supervision of the responsible pharmacist (RP), with the support of the SI. The RP's notice had been placed on display for the team to see. The pharmacy had a set of up-to-date standard operating procedures (SOPs) for team members to follow. And it was clear that they understood their job roles. The RP worked in a central workstation alongside a dispensing assistant (DA)

and a trainee technician. The RP conducted clinical checks electronically from here. The trainee technician worked as a customer services advisor. And she dealt with people's requests and queries from her workstation close to the RP. The DA mainly processed prescriptions and produced dispensing labels. And by working near the RP both the customer services advisor and the DA could easily consult the RP when they needed her advice and expertise. Another DA demonstrated the process by which he could see the electronic record of when a clinical check had been carried out by the RP. And he could demonstrate the use of the barcode recognition system which allowed him to match the dispensed medicine to the prescription. And the correct packing label.

People generally gave feedback through the pharmacy's website. But they also gave feedback directly to team members during phone calls with the customer services manager, the RP or the SI. And they gave their views on the quality of the pharmacy's services. The pharmacy had received many positive comments about its services. It was clear that the RP and SI monitored comments made by people on the website. And the SI described how he and the team tried to manage people's expectations around prescription delivery times. The pharmacy had a complaints procedure to follow if needed. And it could provide people with details of where they should register a complaint if they wanted to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP and SI worked with prescribing services to arrange for alternatives when they received a prescription for an item that they could not get. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records electronically. And it kept them in the way it was meant to, including its RP records. And its CD register. The pharmacy kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. The pharmacy did not receive many patient returns, but the register was complete and up to date. The pharmacy's private prescription records were generally in order. The pharmacy did not generally get requests for emergency supplies. And it was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy was closed to the public. And so, people's personal information, including their prescription details, were out of public view. Delivery drivers and other non-pharmacy staff came to the front door or the rear delivery area but did not enter the main dispensary. The SI had briefed team members, including delivery drivers, on the need to protect people's confidentiality. And he checked their understanding to ensure that people's private information remained protected. The pharmacy discarded its confidential paper waste into a separate container. And team members shredded it regularly each week. The RP had completed level 2 training on safeguarding vulnerable adults and children. And team members had also been trained. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. It had not had any safeguarding concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy regularly reviews its workload and ensures that it has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality and effectiveness of the pharmacy's services.

Inspector's evidence

At the time of the inspection the team comprised of the SI, the RP, two DAs, a pharmacy assistant, and the customer service advisor. They all worked full time. The pharmacy assistant was also a trained DA. There were also two part time dispensers who were not in at the time and two part time drivers. The pharmacy was up to date with the workload. This included attending to people's queries. Team members were aware of what they could and could not do in the absence of the RP. The DA said he would use that time to prepare for the day so they could work more efficiently. Staff performance was managed through appraisals on starting the role and every six months after that. Staff members had the opportunity to also feedback on their own performance and seek support if needed. The pharmacy conducted team meetings twice a week, where staff were encouraged to contribute. Team members had the opportunity to develop their skills through further training and courses. The customer services advisor was completing the technician course and two DAs were completing the accuracy checking course. The RP had completed relevant training to prepare for the launch of the pharmacy first service. The pharmacy did not have the relevant PGDs and competency framework in place, but it had not started delivering the service yet.

The pharmacy team did not have any current targets, but they worked to a timeframe. The pharmacy provided people with estimated delivery times and the team processed the prescriptions within those times. The team members felt that patient safety was not compromised and if the deadlines were not met, they updated people who used the service. Team members felt they could raise concerns comfortably. They had direct access to the RP and the SI. And they knew where to report issues if they had any concerns. The working atmosphere was efficient and calm. And team members were observed openly discussing issues with each other. Most of the team worked full time with sick leave and holidays covered by part time staff. The RP was able to make her own professional decisions in the interest of patients. She could also raise concerns with the SI if she needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was in a small warehouse-style building on a modern industrial estate, with car parking for some staff and visitors. The pharmacy had plenty of space for staff to work safely and effectively. It had windows on two sides providing it with natural light. And additional lighting inside to ensure it was well lit. The pharmacy had a regular cleaning routine. It cleaned its work surfaces, floors and equipment regularly. And team members kept them tidy. Its dispensary had separate areas for different activities. This included the central area of four workstations where the RP and customer services advisor worked alongside a DA. And it had a separate workstation with a bench for assembling medicines. And a further workstation and bench for accuracy checking, packing and dispatch. These benches were near to the pharmacy's storage racks, where it stored its medicines. The remainder of the dispensary had an office and an area for the SI to work. The SI's desk overlooked the dispensary allowing him to oversee the workflow and intervene if required. The pharmacy had staff facilities and a consultation room near its front door. The team had not yet used the consultation room. But the RP and SI hoped to use it soon for additional services such as the NHS Pharmacy First service. Team members tended to use the front door to enter and exit the premises.

The pharmacy had separate double doorway with a shutter at the rear of the premises. It used this for receiving stock deliveries. And for dispatching completed prescriptions for delivery. The outside area near the rear doorway could be accessed by commercial vehicles. Including vehicles making deliveries to and from the pharmacy. The premises had recently been fitted out. And they were bright and modern. They were also clean, tidy and in a good state of repair.
The pharmacy's website displayed its address and registration number as well as the name and registration number of its SI. It also displayed the pharmacy's contact details. The premises were well lit, and the temperature was controlled by a combined heating and air conditioning unit. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy provided its services over the internet. The pharmacy's website gave its times of opening which were 9am to 6pm Monday to Friday. And 9am to 1pm at weekends. And a description of its services and how to access them. People registered for its services on the website. For NHS prescriptions people requested their prescriptions from their GP and gave consent for the pharmacy to receive and dispense them. The pharmacy also requested NHS prescriptions directly from surgeries for a small number of people. After receiving their details and their consent, the pharmacy accessed their prescriptions from the NHS spine. The pharmacy received private prescriptions from various electronic private prescribing services including Emed and BUPA. And it also dispensed paper prescriptions after receiving them in the post. The pharmacy had an online platform which private prescribers could use to generate their prescriptions. And upload them to the pharmacy's electronic system. The system allowed team members to chat and exchange information with both prescribers and people using the pharmacy. The team also emailed people to keep them up to date with the status of their prescription, the availability of their medicines and the expected delivery timeframe. The RP had a smart card with access to Summary Care Records if needed. And the team monitored the amount and frequency of requests for pharmacy (P) medicines to make sure people's health was protected.

The pharmacy had an established workflow where a large proportion of the workload was automated. The DAs scanned medicines that entered and left the premises. They carried out several scanning checks throughout the dispensing process. And they conducted a visual check at the end. An audit trail of who dispensed the item was kept electronically. The RP gave people advice on a range of matters. She did this through the pharmacy's online chat facility or by telephone. And she gave appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets and information cards on a range of medicines including oral steroids and sodium valproate. It had a small number of people taking sodium valproate medicines. The RP counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP was aware of recent changes in the law about supplying valproate medicines in their original packs. She described how the pharmacy received a prescription for a valproate medicine for someone in the at-risk group. But it was not clear if the person was on a pregnancy prevention programme. And so, the RP contacted the clinic to confirm that the item was prescribed according to current guidelines. She then recorded this in the pharmacy's clinical interventions log.

The pharmacy delivered most of its medicines using a combination of the Royal Mail special delivery service and other delivery couriers. It also had its own 'same day' delivery drivers who could make deliveries to people living in most central and west London post codes. The method of delivery depended on the availability of the delivery service at certain times of the day or week. And the urgency

of the delivery. People generally chose the method of delivery they wanted. But team members intervened, with the consent of the patient, if the delivery method was not suitable. This included weekend deliveries which some couriers provided, and others did not. And prescriptions for urgent items such as antibiotics where the team would offer the patient a same day or next day delivery using its own delivery drivers. This was to ensure that people got their medicines on time. And gaps at the weekend or on bank holidays were kept to a minimum. All deliveries required a signature for the person receiving it. It used Royal Mail from Monday to Thursday. The pharmacy provided weight loss medicines and controlled drugs for ADHD against private prescriptions. But before agreeing to supply these medicines the pharmacy ensured that prescribers had the necessary competencies. And a condition of supply was that the patient had to agree to their GP being informed.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. The pharmacy checked the expiry dates of its stock, regularly. And it kept records. When the team identified any short-dated items it highlighted them. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls. But the SI described how the pharmacy's system could quickly access details of anyone who had been supplied with a recalled medicine. This allowed them to respond effectively to patient level recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals in the dispensary. Computers all had password protection. And each team member had their own password and log-in details. Passwords and log-in details were allocated according to job roles. And this provided people with an appropriate level of access to records. And it also provided a time sensitive audit trail of who had accessed which records. This also helped to protect people's private information. People did not generally have access to the pharmacy. And so, the pharmacy could protect their personal information appropriately. The pharmacy had a shredder which it used regularly to dispose of confidential paper waste.

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.