General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacierge Pharmacy, 43A Wimpole Street, London, W1G 8AQ

Pharmacy reference: 9012332

Type of pharmacy: Community

Date of inspection: 07/08/2024

Pharmacy context

This community pharmacy is located near Harley Street in London. It provides most of its services at a distance, but people can also collect their medicines from the pharmacy. Its main activity is the supply of medicines against electronic private prescriptions which are received via its bespoke prescribing platform. Medicines are delivered to people with the use of couriers. The pharmacy does not provide any other services.

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 has written procedures to help make sure team members provide its services safely and effectively. It completes risk assessments and takes actions to help mitigate the risks associated with its bespoke private prescription prescribing platform. And it keeps the records it needs to by law so it can show supplies are made safely and legally. It makes records of mistakes that happen during the dispensing process, and it regularly reviews these so that its team members can learn from them. Members of the pharmacy team effectively keep people's private information safe, and they know how to safeguard people that may be vulnerable.

Inspector's evidence

The pharmacy's main activity was dispensing medicines against private prescriptions which had been generated by prescribers via its online prescribing platform. Written procedures were available which covered the services that the pharmacy provided which helped its team members work safely. The procedures had been periodically reviewed to reflect any changes to processes or new guidance. And they were reviewed every two years to make sure they were all up to date. All members of the team had read the standard operating procedures (SOPs) and had signed a training record to demonstrate this. Roles and responsibilities were stated within the SOPs and team members were able to explain what task they were responsible for. A certificate was available to show professional indemnity insurance was current and it covered the services being provided.

A website, https://www.pharmacierge.com/, had been set up for UK based clinicians with the authority to prescribe to generate electronic private prescriptions for the pharmacy to dispense. Prescribers were required to register with the pharmacy to use the service. Checks of the prescriber's identity, professional registration, and ability to prescribe were carried out and a record of this was made. This part of the process was managed by the practice support team who were separate to the pharmacy team. Ongoing checks of the prescriber's professional registration were completed every month to help make sure they still had the authority to issue prescriptions. Private prescriptions were signed with an advanced electronic signature and the prescriber was required to use a unique PIN number to do this.

The pharmacy received prescriptions through an online platform which has been designed and created by the directors of the pharmacy. Incoming prescriptions were first screened by a trained dispensing assistant or pharmacy technician to make sure all the information needed to safely dispense them was present. If all the information was correct, it was entered on to the pharmacy's computer system so that a record of the prescription was available along with an electronic copy. A further accuracy check was completed by a pharmacy technician working as an accuracy checker (ACT) or pharmacist to help make sure the prescription information had been transcribed accurately. A pharmacist carried out a clinical check against the patient medication record (PMR) and any details from the prescribers such as clinical notes, if available. Once this stage was complete, the prescription was passed on to the dispensing team. A full audit trail was kept showing who was responsible for each part of the process. Some medicines were supplied against prescriptions that had not been received through the online platform. They were usually received by post or hand delivered to the pharmacy. The prescriptions were still processed in the same way as electronic ones and a scanned copy was uploaded on to the system. Prescriptions for controlled drugs (CDs) were dispensed but the pharmacy requested that a hard copy of the prescription was provided before any medicines were supplied. CDs were prescribed

on the correct forms.

Risk assessments had been completed and they covered the services that the pharmacy provided. Risks had been identified around the prescribing platform and mitigations had been recorded which were reviewed quarterly or after a change in process. New risk assessments were completed when a new service, or change to a current one, was being considered. For example, the pharmacy was reviewing the risks around using some of the functionality that was built in to the PMR system, and whether activating the functionality would be appropriate. The pharmacy also completed audits to help maintain a good level of safety. For example, a recent audit had been completed to identify any specific prescribing trends. This had subsequently led to training materials and documents being created for prescribers providing guidance on matters such as controlled drug prescription requirements. Safeguards had been built into the pharmacy's bespoke prescribing platform to help highlight frequent prescriptions and steps had been taken to try and reduce the risk of this. The platform had functionality to mark patients that had recently been supplied a prescription in order to reduce the chance of duplicate or inappropriate supplies being made. It also highlighted if the patient's name was similar to that of the prescriber to reduce the risk of potential self-prescribing or prescribing for family members.

Evidence of the records that were required to be kept and maintained were seen. They were up to date and complied with the requirements. This included a private prescription register, records for the supply of unlicensed medicines, and CD registers which also had running balances. A few running balances were checked against the physical stock and found to be correct. Patient returned CDs were recorded in a book and signed when destroyed. A responsible pharmacist (RP) log was seen, and it was largely completed correctly. Some incorrect entries had been amended but there was no clear record of when and who made the alteration. This was discussed with the superintendent pharmacist (SI) who provided an assurance that amendments will be made correctly going forwards. An incorrect RP notice was displayed in the reception area of the pharmacy. It was promptly corrected when it was highlighted. When questioned, team members were able to correctly explain the tasks they could and could not complete if the RP took a short leave of absence.

A process to record mistakes that happened when prescriptions were assembled was in place. Near misses, which is when a mistake was identified by the person who completed the accuracy check, were recorded on an electronic form. The near miss was discussed with the team members involved and the accuracy checker made the record. However, the recording form did not always capture the specific learnings following the adverse event which would help team members reflect on the mistake and learn from it. It would also help to shape the actions they would take to reduce the likelihood of similar mistakes from happening again. Near misses were reviewed each month and were discussed by the senior management team which included the SI. Presentations were created to identify common trends, and this was shared with the pharmacy team. On some occasions, a 'drug of the month' was identified as a common mistake and a member of the team educated the rest of the team on it. The SI explained the process they would follow if a dispensing error occurred. In this case they would make a record of the error and investigate it to establish the root cause.

A confidentiality agreement was signed by team members when they first commenced their employment at the pharmacy. Annual training was completed to keep their knowledge about information governance up to date. And it was undertaken following any errors which involved a breach of confidentiality. Team members were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacy's computer systems could only be used with an access card to help protect data. The pharmacists and pharmacy technicians had undertaken advanced formal safeguarding training. They had access to guidance and local safeguarding contact details. Team members were able to correctly explain the action they would

take if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to safely manage the workload. And it provides team members with a good level of support to complete any new and ongoing training. The pharmacy's management team proactively review staffing levels and recruit based on predicted future workload which helps to make sure there are enough team members available. Team members meet regularly to discuss any concerns and provide feedback which helps to improve the service they offer for people.

Inspector's evidence

The pharmacy team consisted of nine pharmacists, six qualified pharmacy technicians, three of whom worked as accuracy checkers (ACTs) and seven qualified dispensing assistants. There were also two medicines counter assistants and four pharmacy support staff, who were employed in patient liaison roles or to manage the logistics such as stock handling and courier processes. Some additional team members were also undergoing training to obtain a qualification. This included one ACT, five pre-registration pharmacy technicians (PTPT), three of whom had management responsibilities, and four pharmacy support staff.

The team was large enough to manage the workload safely and effectively. The senior management team included the SI and a Head of Pharmacy Operations, and they worked closely with the directors of the pharmacy. They felt comfortable approaching them with any feedback or concerns. The SI explained that the directors were supportive of the pharmacy proactively recruiting new members of staff based on future workload so that there were enough team members available. The team was split into different sections so that there was an established workflow. This included a dispensary team who assembled the prescriptions, a stock team who managed stock levels and a patient liaison team who were responsible for responding to queries and taking payments. There was also a clinical team which consisted of pharmacists.

The pharmacy had a comprehensive onboarding programme in place for new team members. This included the completion of mandatory training, shadowing sessions and the completion of a training matrix so that they were familiar with the pharmacy's processes. Team members received an annual appraisal to discuss their performance, any ongoing training and to identify new learning needs. Pharmacy team members completed ongoing training, some of which was mandatory such as information governance training or reading new and updated SOPs. Protected learning time was provided so that the learning could be completed in a timely manner. And an electronic log of completed learning was kept.

The pharmacy held an all-staff meeting each month to share key information. This included medicine safety messages, near miss learnings, clinical learnings and feedback from meetings attended by the senior management team. All of the team leads also held meetings with their respective team every one to two weeks. When questioned, several team members felt well supported by their line manager and felt comfortable raising any concerns. The pharmacist felt able to excise their professional judgement and supported each other with clinical issues.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment is suitable for the provision of pharmacy services. The pharmacy premises are bright, clean and tidy. It is well organised to help provide services in a safe manner. And the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The pharmacy recently relocated to a larger premises to help manage the increase in workload effectively. It was large, clean, and well-lit which made it suitable to supply medicines safely. There were two floors of which the first floor housed a reception area and an automated dispensing robot. The basement was used for prescription processing, labelling and dispensing. Medicines were also packaged on this floor ready for a courier to deliver. There was enough organised workspace for its team members to assemble medicines safely. The workflow enabled members of the team to identify where people's prescriptions were in the dispensing process. Different teams were split into different sections of the premises to help with the workflow, and this also helped to make sure the teams were working together if they needed any support. The pharmacy had separate labelling and assembly stations which made it easier to help with the workflow. The pharmacy was renovated to a high standard and fixtures and fitting were in good condition. Clean sinks were available and were suitable for the preparation of medicines.

A consultation room was not available as people did not routinely access the pharmacy but there were several private and confidential meeting rooms available for team members to have a discrete telephone conversation if it was required. The pharmacy had climate control available to help maintain a comfortable working temperature. The pharmacy employed a cleaner who helped to keep the pharmacy clean every day. A clean and tidy staff rest area was available along with WC facilities. A garden area had been designed for team members to take a break when needed. The pharmacy was secured when closed and access to the dispensary and stock areas required a security fob.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It carries out multiple checks to help make sure supplies of medicines are safe and legal. It has processes to make sure the team provides people receiving higher-risk medicines with the correct advice. And it stores and manages its medicines in a way to help make sure they are safe to supply to people.

Inspector's evidence

The pharmacy was open to the public, but most prescription supplies were sent out to people by courier and very few people attended the pharmacy in person. The pharmacy was accessed down two small steps which may make it more difficult for those with mobility issues to enter. However, the entrance led into a small reception area and there were two team members present in this area to help people with access if needed. The pharmacy did not routinely offer any services on the premises and its main activity was dispensing medicines against private prescriptions.

The pharmacy mainly received prescriptions electronically, but in some cases, paper prescriptions were also provided. CDs were only dispensed if the correct paper form was present. Electronic private prescriptions were sent via the pharmacy's prescribing platform. A light technical review of all prescriptions was completed to make sure all of the information required was available and complied with legal requirements. If all was correct and present, prescriptions were transcribed into the pharmacy's computer system and the information was checked for accuracy. The information was then processed and added to the PMR to update the patient's record. A pharmacist completed a clinical check to make sure the supply was safe and appropriate. At this point, the pharmacist added any counselling advice to the system so that it could either be shared with the patient electronically or added to the dispensing label. Higher-risk medicines were identified, and advice was provided to make sure it was used safely. A record of who was involved in all parts of the process was maintained in the event of a mistake or query.

Dispensing baskets were used to help keep different people's prescriptions separate and avoid medicines getting mixed up. A picking list was generated using the PMR and medicine stock was retrieved from the shelve or dispensed by the automated robot. Medicines boxes were scanned into the system to generate a dispensing label. If the incorrect medicine box was scanned, a label was not generated, and the dispenser was required to correct the mistake before proceeding. The PMR system had accuracy checking functionality, but the pharmacy had chosen not to use this. Instead, all prescriptions were accuracy checked by an ACT or pharmacist. Stickers were applied to prescriptions that contained cold chain items or CDs so these could be easily identified and added to the package ready for the courier. Team members were aware of the risks when suppling valproate and isotretinoin containing medicines and advised patients accordingly. Education material was available and provided.

Medicines were delivered to people using courier companies. One was dedicated for deliveries in London and the other for national deliveries. All packages were sent on a tracked and signed for service so that a full audit trail was in place in the event of a query. The pharmacy had informed couriers that medicines can only be delivered to the person and not a safe place. Medicines that required cold storage were packed in appropriate packaging which helped to maintain the temperature that was required to protect the integrity of the product.

A range of licensed wholesalers were used to source medicines and the pharmacy stored them appropriately. CDs were stored in line with requirements and access to them was restricted. They were stored neatly to help reduce the risk of picking errors and obsolete stock was clearly marked and separated. The CD key was kept securely. Medicines that required refrigeration were stored across seven suitable fridges all of which had temperature monitoring in place. The temperature of the fridges was seen to be in range and a record was made daily to audit this. Pharmacy team members checked the expiry dates of medicines on a regular basis. The dispensary was spilt into sections and the checks were completed weekly. And a record of the check was maintained. Medicines stored in the robot were scanned using a 2D barcode as part of the filling process which captured information about its expiry date. Team members were alerted to short-dated medicines so that they could be used first or removed from the robot for destruction.

The pharmacy received alerts about defective medicines and medical devices from the Medicines and Healthcare products Regulatory Agency by email. Its team members checked the medicine stock held against the alert and kept records on a spreadsheet to show what actions the team members had taken and when.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And its facilities help to provide services in a safe and effective manner.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. There were several fridges in the dispensary. Members of the team had access to electronic resources such as the British National Formulary (BNF) and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

Specialised cold-chain specific packaging was used to transport medicines and treatments that required refrigeration. And the pharmacy tested the packaging to make sure the temperature maintained within the required range during the delivery process.

The pharmacy had an automated dispensing robot to help its team members dispense medicines for final checking by an ACT or a pharmacist. The robot was serviced regularly and had a maintenance contract in place. Electrical equipment looked to be in good working order and was last tested in February 2024. Access to people's electronic data was password protected and required an access card. And screens were positioned so they could not be viewed by members of the public whilst they were waiting in the reception area.

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.