General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Wimpole Pharmacy, 18 Wimpole Street, LONDON, W1G 8GD

Pharmacy reference: 1088134

Type of pharmacy: Internet / distance selling

Date of inspection: 29/08/2024

Pharmacy context

This pharmacy operates from a room in a business premises in the Harley Street area of London. It is not open to the public. The pharmacy mainly supplies aesthetic treatments from its website https://wimpolepharmacy.co.uk/. It also fulfils some prescriptions from a third-party website, and a clinic which provides treatments for hair loss. The pharmacy does not offer any NHS services. This was a reinspection as the pharmacy did not meet all standards at the last inspection.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not always seek sufficient assurances that medical prescribers issuing prescriptions for aesthetics products have completed a physical examination of the person receiving the treatment. And it does not always check to make sure that prescription supplies of aesthetic products are being requested and used appropriately. This means people could receive treatments that are not appropriate.
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 not all met**

Summary findings

Whilst the pharmacy had made some minor improvements to its working practices, it has not fully addressed the risks highlighted at the previous inspection when supplying aesthetics products. It does not always seek sufficient assurances that the medical prescribers it works with have completed a physical examination of the person receiving the treatment before issuing a prescription. And it does not always make appropriate checks to make sure that prescription supplies of aesthetic products are being requested and used appropriately. This means people could receive treatments that are not suitable. The pharmacy generally keeps appropriate records, and the team keeps people's personal information safe.

Inspector's evidence

The pharmacy primarily dispensed prescriptions for non-surgical cosmetic treatments including dermal fillers, botulinum toxins, weight loss medicines, and hair loss treatments. These were usually supplied directly to practitioners or clinics for them to administer or supply to people. The pharmacy only dispensed prescriptions for people based in the UK. The company also fulfilled non-prescription stock orders for aesthetic products from a room next door to the pharmacy.

People were required to register an account to request supplies via the Wimpole Pharmacy website. Only healthcare professionals who were accredited to prescribe were able to register to access the area of the website which allowed them to generate and issue electronic prescriptions. Prescribers provided their professional registration details and uploaded a photographic identity document when creating an account. They were also required to provide proof of their professional indemnity insurance and aesthetic training. The details were checked and verified by a customer service assistant when an account was created. Account details and registration information was held on the software system. Following the last inspection, the pharmacy had introduced an additional check of the date when a prescriber's professional registration was due to expire, so team members were prompted to confirm that they had successfully renewed their registration. The pharmacist described an occasion when they had identified a prescriber who was not eligible to prescribe and refused to dispense a prescription that they had issued. But this had been identified by chance, and the pharmacy did not routinely make checks in the interim to confirm a prescriber remained eligible to prescribe. This could mean that people who registered with the pharmacy might continue to issue prescriptions despite conditions on their practice preventing them from prescribing. The superintendent agreed that the pharmacy would check the regulators' adjudications on a regular basis to mitigate this risk.

Prescribers who registered with the website were from various healthcare professions, including doctors, dentists, nurses, and pharmacists. When issuing a prescription, prescribing practitioners were required to confirm they complied with the pharmacy's terms and conditions. The date of birth of each person receiving treatment was also supplied, as confirmation that treatments were not being carried out on individuals who were under the age of 18. The pharmacy had introduced a simple questionnaire which prescribers were required to complete when issuing a prescription. It was dated and included basic clinical checks and a description of the treatment. This provided more assurance about the treatment being provided and supported more effective clinical checks. The pharmacist considered the date on the medical form to be the consultation date, but this wasn't made completely clear, as there wasn't an explicit declaration confirming that a physical examination of the person receiving the

treatment had been carried out. And a number of the prescriptions seen indicated that there was significant distance between the address of the person receiving the treatment and the prescriber, which suggested that the consultation had not taken place in person.

The pharmacy no longer worked with the GMC registered doctors it had previously been working with at the last inspection. Instead, it had a new working arrangement with a nurse prescriber, who was an aesthetics practitioner. They issued prescriptions on behalf of non-medical aesthetic practitioners who registered via the website but were not able to prescribe. Non-medical practitioners were also required to provide proof of their identity and aesthetics training when registering with the pharmacy. The pharmacist was in regular contact with the nurse prescriber and described them as an experienced aesthetics practitioner. They believed that the nurse prescriber had some contact with the person receiving the treatment who was named on the prescription, but a physical examination was not usually carried out. Although aesthetic products are not intended for self administration, some prescriptions were delivered to the person named as the patient on the prescription. The pharmacist admitted that they had not made any further checks to understand why this was, so they could be assured that aesthetic products were being requested and used appropriately.

A number of prescriptions were received from a third-party website. Practitioners using the website were able to register for an account which provided them with access to the website's electronic prescription portal. Faces Consent completed the registration checks. Since the last inspection, the pharmacist had been permitted access the third-party website. This meant they could better assure themselves of the checks that were completed by the third party to make sure prescribers were legitimate.

The pharmacy had standard operating procedures (SOPs) which covered the operational activities in the pharmacy. The SOPs had updated some of these since the last inspection to reflect some systems and processes that the pharmacy had introduced more recently. Records indicated team members had received training on the SOPs with the exception of the pharmacist, who had read them, but not had the opportunity to sign as confirmation of this. The pharmacy kept records of any incidents and the superintendent was informed. Pharmacists reflected on any incidents or issues, and shared learning with each other. A complaints policy was explained on the pharmacy's website.

The pharmacy had up to date professional indemnity insurance for the services provided. The responsible pharmacist (RP) displayed their notice in the pharmacy, and an RP log was maintained. Private prescription records were kept electronically using the facility in the patient medication record system (PMR). A small sample of records were viewed and seen to contain the correct information. The pharmacy did not supply controlled drugs (CDs) and it did not have any CD registers. It supplied some unlicensed specials hair loss preparations on prescriptions for a private hair loss clinic nearby, and it kept records of these supplies which identified batch numbers and supplier details.

The pharmacy was registered with the Information Commissioner's Office. Its privacy policy on the website explained how the pharmacy used and processed people's data. Confidential waste was disposed of using a shredder. Team members with access to personal information understood that this should not be disclosed outside the business. Pharmacists had completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small close-knit team. Team members work well together, and they are competent to perform the roles in which they are working.

Inspector's evidence

The pharmacy team comprised of the regular pharmacist and the superintendent pharmacist, who were both present at the inspection, and a trainee dispenser who was absent. The superintendent did not work in the pharmacy itself but provided ad hoc cover for the RP if needed.

The team was not usually working under pressure, and the workload was manageable. The pharmacist had completed a training course in aesthetics and felt competent in their knowledge of aesthetic products and treatments. The trainee dispenser had previous experience of working in a pharmacy. They had worked at the pharmacy for around a month. The pharmacist said they were intending enrolling them on a course once they had completed their induction. Three team members worked in the room next to the pharmacy processing orders, assembling and dispatching stock orders. The customer service assistant completed registration checks, processed orders, and directed prescriptions to the pharmacy. Whilst the team members had not completed any formal pharmacy training, there was a staff policy and they read procedures covering matters such as handling complaints, health and safety, and confidentiality. Team members worked collaboratively with the pharmacists. They felt able to contribute ideas and raise issues with the superintendent if needed. For example, the pharmacist had made suggestions to improve the working practices, such the clinical questionnaire, which had been adopted.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for the services it provides. It is clean, secure and suitably maintained. The website contains essential information about pharmacy.

Inspector's evidence

The pharmacy was situated on the ground floor of the building. It consisted of a small room fitted with work benches, cupboards and shelving. The pharmacy was bright, clean and well presented. There was enough bench space to assemble prescriptions safely. The non-pharmacy areas included a small reception area next to the entrance to the pharmacy, and the room used to store, assemble and dispatch non-prescription stock orders. Air conditioning controlled the room temperature in both rooms. The pharmacy was only accessible if the pharmacist was present. Both rooms were kept locked when not in use.

The Wimpole Pharmacy website displayed the details of the pharmacy, including the registration number, address and details of the superintendent pharmacist. The regular RP's name and their registration number was also stated.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy stores and manages medicines appropriately. It assembles, dispatches, and delivers prescriptions in an efficient manner. But it sometimes dispenses aesthetic products without making sure that they are being prescribed and used appropriately.

Inspector's evidence

People using the pharmacy's services contacted the team directly via telephone, email or by a messaging service. Most prescriptions were received electronically and were printed before the appropriate stock was selected and dispensed. The pharmacist checked the clinical questionnaire to ensure prescribing was appropriate, and contacted the prescriber for clarification if anything was of concern. For example, the pharmacist gave examples where she had queried prescribing of large quantities for the same person. Some prescription supplies had been delivered directly to the person named as the patient on the prescription, which was unusal as the products should only be adminstered by a trained practioner and should not usually be self administered. The pharmacy had not made any addtional checks to seek assurance prescription items were being used appropriately. This was discussed with the pharmacist.

A small number of practitioners working in clinics locally opted to collect their orders or prescriptions in person, but most prescriptions were delivered by a courier the same or the following day. Deliveries could be tracked. Medicines were securely packaged for delivery. Standard items were placed in discreet cardboard boxes labelled with the delivery address. Cold chain items were stored in the fridge and were placed in plastic bags and packaged together with cold packs. The superintendent confirmed that the pharmacy had completed a delivery audit using a data logger to confirm that the temperature range stayed within acceptable limits during the delivery process although this had not been documented. The courier service collected prescriptions in the afternoons when the pharmacist was present.

Aesthetics products were sourced from licensed suppliers and manufacturers. Stock management and organisation in the pharmacy had improved since the last inspection, and storage shelves and medical fridges were neat and tidy. The pharmacy fridges were fitted with a thermometer. Maximum and minimum temperatures were recorded daily and appeared to be in a suitable range. Some products such as dermal fillers which the pharmacy sometimes supplied on prescription were stored in the room next door. The temperature was monitored in both rooms to make sure it was suitable for the storage of aesthetic products. The pharmacy was subscribed to received MHRA email alerts and the system was checked daily. Manufacturers also alerted the pharmacy to issues with products such as dermal fillers. Unwanted medicines were separated and disposed of via an authorised pharmaceutical waste contractor.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It has appropriate systems in place to protect people’s confidentiality.

Inspector's evidence

The pharmacy had internet access and the pharmacist could access suitable reference sources. Electrical equipment was in working order. Computer systems were password protected. There were five medical fridges used to store medicines. The pharmacy team had access to suitable materials for packing and dispatching medicines, including insulated packaging for cold chain medicines.

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.