General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knightsbridge Pharmacy, 156 Brompton Road, LONDON, SW3 1HW

Pharmacy reference: 1108267

Type of pharmacy: Community

Date of inspection: 15/07/2024

Pharmacy context

This is a late-night pharmacy located on a busy high street in central London. The pharmacy does not provide NHS services. It sells over-the-counter medicines and dispenses private prescriptions generated by external prescribers as well as an in-house pharmacist prescriber. The pharmacy also provides aesthetic treatments such as antiwrinkle injections and dermal fillers.

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 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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines properly or securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. And it protects people's personal information.

Inspector's evidence

Dispensing mistakes which were identified before a medicine was supplied to a person, known as near misses, were seen to be routinely recorded. The responsible pharmacist (RP), who was a regular locum pharmacist said that the near misses were discussed and reviewed with the team, but reviews were not documented. This may make it harder to check if action points were implemented. The RP was not sure where to document dispensing mistakes which had reached a person, known as dispensing errors. They checked the pharmacy's standard operating procedures (SOPs), but the relevant SOP had not been updated and still referred to the National Reporting and Learning System which was now obsolete. The superintendent pharmacist (SI), who joined the inspection at a later stage, said that they would review and update the SOPs.

Team members had signed the pharmacy's SOPs to confirm that they had read and understood them. These had been prepared in 2022 and were due to be reviewed in September 2024. Staff roles and responsibilities were clearly outlined within the SOPs. The dispenser was seen following the SOPs when dispensing prescription medicines. They were also aware of what they could and could not do in the absence of the RP.

The SI, who was also a pharmacist independent prescriber (PIP) had recently started providing a private prescribing service. They mainly prescribed licensed weight loss medicines such as Wegovy and Mounjaro after face-to-face consultations. The SI had completed a risk assessment for the prescribing service, but this mainly covered adverse effects of the medicines. They said that they would complete a more comprehensive risk assessment. The pharmacy had not yet done a clinical audit for its prescribing service as the service had only been introduced several months ago. The benefits of regular reviews of the prescribing service were discussed with the SI.

The pharmacy had current professional indemnity and public liability insurance. The RP sign was clearly displayed, and samples of the RP record seen were in order. Private prescription and emergency supply records were held electronically, and these were in order. The pharmacy had not dispensed unlicensed medicines for some time. A sample of controlled drug (CD) registers was inspected, and these were seen to be well maintained. The physical stock of several CDs was checked and matched the recorded balance. Balance audits were conducted regularly. CDs which had been returned by people were recorded in a separate book and destroyed in a timely manner.

The pharmacy's prescribing records for the weight-loss service included details about the person's medical history, their weight and body mass index, and information about their lifestyle, diet, and physical activity. The SI said that they checked the person's weight before repeat supplies but did not maintain records about these checks. Following the inspection, the SI sent a copy of an updated clinical

record form to help keep track of the person's weight loss progress, and any changes in their medical conditions. The SI said that they would ask people to fill the forms out before any further prescriptions were issued in the future.

The aesthetics service was provided by another pharmacist. The SI prescribed botulinum toxin for use by the aesthetics pharmacist. Records about this service were maintained and included consent forms which were signed by people accessing the service, as well as treatment notes. The treatments notes however did not always include details about the treatment reviews carried out. This may make it difficult for the pharmacy to deal with any queries in the future. The SI said that they conducted face-to-face consultations with the patients, alongside the pharmacist providing this service before prescribing botulinum toxin via an online pharmacy platform. There were no records of these face-to-face consultations. Procedures, risk assessments, and training certificates relevant to the aesthetics service were not available during the inspection. The SI sent these documents following the inspection. The risk assessment covered a range of potential risks including systemic reactions, injection site reactions, psychological risks and legal risks.

People were able to raise concerns verbally or online. A feedback box and paper slips were available in the retail area for people to write down any feedback.

Team members had been provided with verbal training about information governance and data protection. They had also signed the pharmacy's privacy agreement. The dispenser did not know about the General Data Protection Regulation. The SI said that they would provide additional training for the team. Several consultation rooms were available for private conversations and services. Computers were password protected and confidential waste was collected in a separate basket and shredded. Prescriptions and medicines awaiting collection were not visible to members of the public.

Both the RP and SI had completed Level 3 training about safeguarding vulnerable groups. The dispenser had completed training through the dispensing course they had been enrolled on. They were able to describe signs of abuse and how they would handle concerns. The contact details of the local safeguarding team were displayed in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members can raise any concerns or make suggestions. They are not always provided with structured ongoing training which could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

During the inspection, there was a dispenser and the RP present. The SI arrived part-way through the inspection. Team members had completed accredited training courses relevant to their role. The team felt there were sufficient staff to manage the workload in the pharmacy and cover any team holidays. The team members did not receive structured ongoing training or dedicated time to complete training. However, they were provided with regular updates about new medicines and drug alerts by the pharmacists.

Team members had regular appraisals every six months where they discussed their ongoing performance and development needs. And they were also set targets during these reviews. The team members did not feel the targets affected their professional judgment when carrying out their role. Staff felt comfortable about raising concerns or giving feedback to the SI and felt they could also speak to the owner if needed. And they had regular team meetings where they could discuss any issues. The dispenser understood their responsibilities when selling Pharmacy-only (P) medicines. For example, they would refer people to the pharmacist if appropriate when selling higher risk medicines.

The SI’s initial scope of practice for prescribing was in diabetes. They described some ongoing training that they had completed, for example, attending webinars and CPD seminars about weight loss injections. And they generally restricted prescribing to weight loss medicines and minor ailments.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure and clean environment for the pharmacy's services. Because the consultation rooms can only be accessed down some steps, some people may find it harder to have a private conversation with pharmacy staff.

Inspector's evidence

The pharmacy premises were clean and secure. They consisted of a retail area, pharmacy counter and a dispensary on the ground floor. The dispensary was small but was a suitable size for the services the pharmacy provided. The consultation room, blood testing room and two treatment rooms were located in the basement of the premises. And there was also a stock room which was accessed via the consultation room.

The consultation room allowed for people to have a private conversation if required. However, this was accessed via stairs to the basement so may mean that people with mobility issues may not be able to use it. The RP said that people were signposted to other service providers if they required a private area. There was no confidential information visible in the consultation room. Staff facilities included a WC with wash basin and a small kitchen area.

The pharmacy premises were well maintained and projected a professional appearance for a healthcare setting. A cleaner and the team ensured the pharmacy was kept clean and tidy. The temperature and lighting were suitable for working and storage of medicines. Pharmacy medicines were stored behind the counter and excess stock was stored in the basement area in cupboards.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store its medicines properly or securely. But otherwise, the pharmacy generally provides its services safely. It gets its medicines from reputable suppliers. People with a range of needs can access the pharmacy's services. And people taking higher-risk medicines are provided with appropriate advice about their medicine.

Inspector's evidence

Access into the pharmacy was via a step. Team members could see when a person was entering the pharmacy and could assist them if necessary. There was sufficient space in the retail area for people with wheelchairs or pushchairs to manoeuvre. The consultation rooms were in the basement and could therefore not be accessed by those in wheelchairs. The RP said that people were signposted to other service providers if they required a private area. Labels with large font could be created for people as required and the RP described sending video guides by manufacturers when possible. Some members of the team were multilingual and translated for people who did not speak English well. This was useful as the pharmacy was in a largely touristic area. The pharmacy was open until 11pm during the summer season.

Team members were observed confirming the person's details when handing out dispensed medication. They also requested a form of ID when handing out Schedule 2 CDs. Colour-coded baskets were used separate different people's prescriptions and prevent the transfer of medicines. There were designated areas to dispense and to check prescriptions. Workbenches were kept clear from clutter. 'Pharmacist information forms' were seen to be attached to dispensed prescriptions. These were used to highlight any additional information, for example, brand preference. Dispensing audit trails to identify who dispensed and checked medicines were completed.

Team members had read the guidance about sodium valproate and were aware of the need to supply this medicine in its original pack. The RP described additional checks that they would carry out, for example, checking if a Pregnancy Prevention Plan was in place if a person was in the 'at-risk' group. Team members were not aware of the government restrictions on the use of puberty suppressing hormones but said they would read the guidance and familiarise themselves with it.

In date and signed Patient Group Directions were available for the travel vaccine service. The pharmacy kept a record of supplies made as part of this service on an electronic platform. The pharmacy provided a phlebotomy service through two laboratories. Once collected by the pharmacy team, specimens were sent to the laboratories via a courier. The results were sent to the pharmacy via an online platform, and these were shared with the person. The SI said people were signposted to their GP if a test result was outside the reference range.

Approximately 90% of prescriptions generated by the SI were for weight loss injections. The SI said that they would only prescribe unlicensed medicines such as Ozempic if there were shortages of the licensed medicines. They did not maintain records of prescribing rationale which may make it difficult to explain why a particular medicine was chosen in case of a future query. Most consultations were face-to-face. The SI explained that some consultations were done virtually, but people were asked to attend the pharmacy for a weigh-in and to collect their medicine. Prescribing records included information

about the person's medical history, their lifestyle, weight, height, BMI, and allergies. People were required to read and sign a form which listed the contraindications, and possible adverse effects. The pharmacy did not routinely obtain consent to share details of any supplies with the person's GP. And the pharmacy was not keeping records of any treatment reviews carried out. This may make it difficult to justify repeat supplies. The SI provided examples of rejected requests, for example, when a person's BMI did not meet the threshold. Following the inspection, the SI sent a copy of an updated clinical form which included a request for the person's GP details and consent to share details of supplies with them.

Stock was obtained from reputable wholesalers. Medicine packs were seen to be mixed inside boxes on the shelves. This may increase the likelihood of picking errors. The SI said that they would review this storage arrangement. Some CDs requiring safe storage were not stored in accordance with legal requirements. And some P-medicines were stored in a location which was not secure and where they could potentially be accessed by people using the pharmacy. Expiry date checks were conducted regularly, and clear records were maintained to confirm this. Medicine with short expiry dates were highlighted with a coloured sticker. The fridge temperatures were monitored daily. Records indicated that the temperatures were maintained within the recommended range. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received electronically, actioned and documented.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had access to the internet to allow team members to access any online resources they needed. The computer screens were not visible to people who used the pharmacy. All computers were password protected to protect people's information from unauthorised access. And there was a cordless phone available so phone calls could be taken in a more private area if required.

The pharmacy had two fridges for medicines requiring cold storage. One fridge was in the dispensary and one was located in the consultation room. And there were two secure CD cupboards. There were three plastic measuring cylinders for measuring liquid medicines, but these were not appropriate for use. The SI said that he would replace these with suitable crown-stamped calibrated measures. There were clean tablet and capsule counters available.

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.