General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ways Pharmacy, 77 Southampton Row, London, WC1B 4ET

Pharmacy reference: 9012227

Type of pharmacy: Community

Date of inspection: 22/10/2024

Pharmacy context

This is a community pharmacy in central London. It does not have an NHS contract. But it does sell over-the-counter medicines and it dispenses private prescriptions and supplies medicines via patient group directions (PGDs). The pharmacy provides the following services: phlebotomy, prescribing, weight loss, aesthetics, a variety of vaccinations to protect people against childhood diseases or when they are travelling.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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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 identify or manage the risks for providing a prescribing service. It does not have sufficient risk assessments, procedures or policies in place to provide a prescribing service safely.
		1.2	Standard not met	The pharmacy does not routinely audit the safety and quality of the prescribing service.
		1.5	Standard not met	The pharmacy does not have adequate professional indemnity insurance arrangements for all of its services. The remote consultations for the prescribing service being undertaken by the PIP are not covered by the current arrangements.
		1.6	Standard not met	The PIP attended the pharmacy in person or worked remotely to prescribe medicines. It was not clear who verified what was prescribed as there were no records of these consultations in this pharmacy and the SI at this pharmacy did not have access to the consultation notes when medicines were prescribed remotely.
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	4.2	Standard not met	The pharmacy does not manage and deliver its private prescribing service safely. It may not verify what has been prescribed and medicines may be supplied against prescriptions which are not valid. Some prescriptions from the PIP did not meet legal requirements. The PIP used a computer-generated prescription template with an image of her signature and registration number. She did not counter-sign paper copies of prescriptions in indelible ink or provide the original prescription with a wet signature or a valid electronic prescription when prescribing remotely. But people were able to collect their prescription medicine from the pharmacy.

Principle	Principle finding	Exception standard reference	Notable practice	Why
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately assess the risks of providing a private prescribing service to people. It does not have written risk assessments, procedures, prescribing policy, or formulary for its service. The pharmacy's team members do not routinely assess the risks and monitor the safety and quality of the services they provide. The pharmacy does not regularly review any written instructions which could tell its team members how to carry out their tasks. That means they cannot be sure they are adequately managing the risks of providing their services. They are dispensing prescriptions that do not meet legal requirements. The pharmacy does not keep all the records required by law and it doesn't ensure that it is adequately insured for all of its services. The pharmacy team members understand their roles in protecting vulnerable people and private information.

Inspector's evidence

The responsible pharmacist (RP) said the pharmacy provided services to ‘walk-in’ and virtual clients. And it dispensed low numbers of private prescriptions. The pharmacy provided treatments via patient group direction (PGD) as the pharmacy had the complete range of available PGDs from one source. The RP who was also the superintendent pharmacist (SI) did not have risk assessments for all the services provided. And the pharmacy team had not conducted audits to monitor the services and their quality. The SI had applied for Care Quality Commission (CQC) registration.

The RP did complete the consultations on a record sheet which was provided with each vaccine prior to administering the vaccinations. These were pre-populated with questions about the persons health, age and allergy status so they regarded them as risk assessments for the vaccinations. The RP recorded the vaccine batch number and expiry date on the same consultation sheet. The completed consultation record made sure vaccines and affected people could be traced in the event of a recall.

The pharmacy offered a prescribing service but a risk assessment and formulary were not available during the inspection. A pharmacist independent prescriber (PIP) attended the pharmacy in person or worked remotely to prescribe medicines to treat conditions such as acne or for contraception. She used a computer-generated prescription template with an image of her signature and registration number. She did not counter-sign paper copies of prescriptions in indelible ink or provide the original prescription with a wet signature when she had prescribed remotely but in spite of this people were able to collect their prescription medicine from the pharmacy. The prescriptions were sent by email to the pharmacy without consideration of the need to supply an original signed prescription or a valid electronic prescription. It was not clear who verified what was prescried and the RP did not have access to the consultation notes when medicines were prescribed remotely. Prescriptions from the PIP did not meet legal requirements and the RP was unaware these were not legal. Those prescriptions sent electronically to the pharmacy did not include a valid digital signature meeting the required standard. And when the PIP in Nottingham was conducting a consultation remotely it was not clear how identity checks were completed. The prescriber was based in the pharmacy in Nottingham and

completed virtual consultations. Some of which were with the person sitting in the consultation room in this pharmacy. But there were no records of these consultations in this pharmacy.

The pharmacy provided the weight loss service through a PGD and all people were seen face to face. The RP described identifying people who did not comply with the pathway for weight loss service by checking their BMI and other risk factors. The phlebotomy service was facilitated through a London-based UKAS accredited provider of clinical services. Although an aesthetics service was on offer from the pharmacy's premises, a risk assessment and training certificate of the practitioner qualifications were not available during the visit. But after the visit the RP supplied evidence of training in aesthetics. The RP did not have completed audits to share during the visit. And there were no records to show that the pharmacy had refused to make a supply on the basis of people failing to meet the necessary criteria in the PGD. Consultations were completed and stored online. The RP had documents translated into Chinese to assist patients answering questions.

A pharmacy team member explained the dispensing and checking procedures which she followed when she was dispensing a prescription. And she was aware of what pharmacy activities she was able to undertake in the absence of the RP. The medicines counter assistant (MCA) described what medicines she would sell and when she would refer to the pharmacist for assistance. For instance, when people were trying to purchase medicines liable to abuse.

The pharmacy did not have standard operating procedures (SOPs) for most of its services. But it did have them for its RP procedures. Team members hadn't signed the training records to show that they had been trained on the SOPs. A member of the team described the protocol for recommending and selling over-the-counter medicines. People could leave feedback about the pharmacy via Google review or Trustpilot. And the RP said they followed up on negative feedback.

The pharmacy had insurance arrangements in place, including professional indemnity, for services it provided. But according to the schedule, some services may not be fully covered. For instance, where remote prescribing takes place. No records of refusal to supply medicine was seen at time of inspection. The pharmacy did not supply controlled drugs. The pharmacy recorded supplies it made via PGD and the private prescriptions it supplied electronically. And these generally were in order.

The pharmacy displayed two RP notices so it was not clear which RP was securing the safe and effective running of the pharmacy when it was operational. The pharmacy had a record to show which pharmacist was the RP at any given time. But the RP record was not regularly completed by the RP on duty in line with requirements. A member of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy received feedback from people online via Google and Trust Pilot. The RP followed up negative feedback.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice on its website that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy collected people's personal information and kept it safe. It was disposed of securely. The pharmacy computer was password protected. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team had completed level 2 safeguarding training. They knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. The pharmacy provides them with ongoing training in product knowledge. And they feel able to make suggestions which improve the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (SI) (also the RP), a full-time dispensing assistant, and a full-time medicines counter assistant (MCA). The pharmacy relied upon its team to cover absences. The MCA had completed accredited training for which the RP provided a certificate of completion. The SI used the PGD provider's portal for self-certification of PGDs. The SI had undertaken resuscitation training but not recently. And he had completed the PGD provider's training package.

A member of the pharmacy team had undertaken accredited training but the role and training status of the remaining team members was not explained. The GPhC training requirements for support staff were discussed during the visit. The pharmacy team were provided updates on COVID and some ongoing training through industry publications which contained new product information. The RP said the team members could read training information when it was quiet in the pharmacy. They worked well together serving people and signposting them elsewhere if the pharmacy was unable to supply a service or medicine they were seeking. Team members had suggested creating a waiting list of people for a particular medicine. The RP had completed training to provide treatments and medicine via the range of PGDs. And he could refer to the PGD providers when dealing with queries.

After the visit, the RP was able to send assorted documents as evidence of completed team training such as scope of practice of the PIP who provided the prescribing service. The aesthetics practitioner had completed training in a variety of treatments and injectable therapies.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure, clean and bright. The location and layout of the pharmacy's consultation room protects people's privacy. The pharmacy presents a suitable environment from which to provide pharmacy services. And the pharmacy is secured when closed keeping its medicines and equipment safe.

Inspector's evidence

The registered pharmacy premises were newly renovated and refitted, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a retail area, a medicines counter, a small dispensary along with treatment and storage rooms in the basement. The pharmacy had a consultation room where people could have a private conversation with a team member. The dispensary had limited workspace and storage available. A cleaner was responsible for keeping the pharmacy's premises clean. There was seating for people who wanted to wait.

Parts of the websites were difficult to read as they appeared to have been translated into English. Some information on the websites was available in Chinese script. Despite the RP describing the pharmacies as separate legal entities, details of both pharmacies were advertised clearly on both websites. It was highlighted that antibiotics (clarithromycin and phenoxymethylpenicillin) could be selected without completing a questionnaire consultation, and just put in a basket. The medicines selected on the website were delivered and/or collected from this pharmacy 9012227. But following the visit, the website had been amended inviting the person to complete an assessment before obtaining the medicine.

The website mentioned 'Online Doctor' which was misleading as the services were offered through PGDs rather than an online doctor. Following the inspection this was updated on the main header of the website but it still mentioned 'Online Doctor' elsewhere on the website. The website provided no details about the prescriber. The pharmacy's website used the PGD provider's questionnaire as an assessment tool, but people could select a medicine first and not a condition which is not in line with current guidance.

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

Summary findings

The pharmacy does not manage its private prescribing service safely. It does not have adequate safeguards in place to help protect people when they use its prescribiing service. Neither the prescriber nor the responsible pharmacist demonstrate sufficient insight into the risks associated with running their private prescribing service. The pharmacy makes its services easily accessible to people, and it obtains its stock from licensed wholesalers. It stores its medicines securely at the right temperature and it makes regular checks to ensure they remain safe to supply.

Inspector's evidence

The pharmacy's entrance was level with the outside pavement. This made it easier for people who used a wheelchair, to enter the building. The pharmacy team tried to make sure people could use the pharmacy services. The website displayed the pharmacy's opening hours. The pharmacy had a small seating area for people who wanted to wait. The pharmacy team signposted people to another provider if a service was not available at this pharmacy. Some team members could understand and speak Mandarin and Cantonese. They printed off patient information leaflets (PILs) to provide people with information about their medicines.

The RP explained that the pharmacy advertised an 'Online Doctor' service as this was easier for people to understand. But this was misleading and inaccurate for people who accessed services as these services were run via PGDs. And the pharmacy had the complete range of available PGDs from one source. The RP said team members would contact the PGD helpline if they had any issues with the PGD and questions people had raised.

Information on the websites indicated people could choose to receive their medicine by post, a local pick-up point or by attending Ways pharmacy 9012227 only. The pharmacy used a third-party delivery App for delivering over-the-counter (OTC) medicines only, and there was no SOP in place for this service. But the RP could intervene at any time. Other items were sent via the Post Office or Royal Mail.

The RP said the PIP training had been in dermatology and that the PIP had a formulary and her own risk assessment (RA) but these were not seen during the visit. The RP described a scenario where a person came into Ways Pharmacy 9012227 for treatment for acne by PGD. The PIP would also prescribe lymecycline via a website RA and video call. If the PIP prescribed remotely in the other pharmacy it meant the original prescriptions were at that pharmacy.

The PIP came to the pharmacy and prescribed for conditions such as acne, oral contraceptives. The consultation took place face-to-face in Ways Pharmacy 9012227 or else the patient and pharmacist sat

in the consultation room in Ways Pharmacy 9012227 and the PIP was in the second pharmacy and sent the prescription to Ways Pharmacy 9012227. It was unclear who verified what was prescribed. And a RA for this prescribing service was not seen.

Evidence gathered during the inspection of the second pharmacy indicated the PIP was prescribing for a range of medical conditions. The RP provided a series of scope of practice documents for the PIP. The documents named the locations and the PIP and the review date was September 2025. Scope of practice included treatment for urinary tract infections, EVRA, acne and emergency supplies of insulin and medicines for people visiting from outside the UK. The origin of the documents was not clear. The PIP issued a small number of prescriptions per month and these were dispensed onsite at Ways Pharmacy 9012227. Some of the prescriptions appeared to be transcribed from Chinese for people who had forgotten to pack enough medicine before coming to London on holiday.

The pharmacy provided an aesthetics service for injectable botulinum toxin in treatment rooms in the basement. The RP explained that the PIP prescribed the botulinum toxin. Two other doctors prescribed and administered botulinum toxin. Supplies of botulinum toxin were obtained from Church Pharmacy. The botulinum toxin was administered by a level 7 accredited nurse. First of all, the practitioner checked age and identity and refused to treat people under 18 years old. A patient RA was completed and the patient signed giving consent. The RP said the practitioners had their own professional indemnity for personal liability. The consultation notes were recorded on Pabau (digital patient clinic notes) and the RP said there was an emergency kit to reverse effects if needed. The pharmacy also provided a range of vaccinations such as flu vaccinations on a walk-in or book online basis. The RP completed a PGD provider's data entry including consent. The person was informed that the vaccination was free of charge through the NHS and given a supply record to give to their GP.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. The dispensary was limited in size and the team kept it tidy. The pharmacy team checked the expiry dates of medicines regularly. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius which was monitored through a data logger. The pharmacy did not stock controlled drugs requiring safe custody. The pharmacy provided a variety of vaccination services but the empty vials were not disposed of in the correct clinical waste bins. Following the visit, the RP arranged a Service Agreement to remove medical and pharmaceutical waste safely in the appropriate containers. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took, the yellow card scheme and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And its team makes sure the equipment protects private information.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And a logger recorded and monitored the maximum and minimum temperatures of the refrigerator. The pharmacy collected confidential wastepaper for secure disposal. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. Making sure the blood pressure monitor was regularly calibrated was discussed and the pharmacy had its own defibrillator.

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.