General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wigmore Pharmacy, 17, 19, 21, 23 Wigmore Street, London, W1U 1PL

Pharmacy reference: 9012271

Type of pharmacy: Community

Date of inspection: 07/08/2024

Pharmacy context

This pharmacy is located in central London. It operates as a retail pharmacy dispensing prescriptions and providing walk-in services, and it has a website, https://www.wigmoremedical.com/, for the supply of aesthetics treatments and skincare products to prescribers and aesthetic practitioners. The pharmacy dispenses a high volume of private prescriptions and also provides other services such as seasonal flu vaccinations and blood pressure testing. A phlebotomy service is also available. The pharmacy has a wholesale dealer's licence enabling it supply aesthetic products as stock. This activity is regulated by the Medicines and Healthcare products Regulatory Agency and so outside the scope of this inspection.

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 generally identifies and manages the risks associated with its services in an effective manner. It keeps the records it needs to by law and takes the necessary steps to keep people's information safe. Members of the team are aware of how to keep vulnerable people safe. Its team members make a record of mistakes that happen so that they can learn from them. But mistakes are not reviewed so common mistakes and trends may not always be identified. The pharmacy carries out some initial checks of the prescriber's registration status when they register to access the aesthetic services and use its online electronic prescribing platform available on the website. But subsequent checks are infrequent, so there is a risk of prescribers issuing prescriptions without the authority to do so.

Inspector's evidence

The pharmacy had recently expanded the premises that it operated from to help manage the increase in workload. Team members had access to paper standard operating procedures (SOPs). These covered the operational activities of the pharmacy and the services provided. SOPs appeared to have been recently reviewed most team members had read and agreed the SOPs that were relevant to their role. The superintendent pharmacist (SI) admitted that some team members were still yet to sign the new set of SOPs and provided an assurance that this would be completed immediately. Members of the team were knowledgeable about their roles, and they explained what workload they were assigned to complete under the supervision of the responsible pharmacist (RP). They were aware of the tasks that could and could not be completed if the RP took a short leave of absence, although this rarely happened as there always more than one pharmacist working at the pharmacy every day.

The pharmacy held an NHS contract, but it dispensed very few NHS prescriptions. It sold a wide range of medicines and beauty cosmetic products over-the-counter, but its main activity was providing the aesthetic service. The service was provided through its website https://www.wigmoremedical.com/. The website offered a wide range of aesthetic and skincare products, including some medicines, and associated consumables, such as syringes and gloves, for use alongside aesthetic treatments. The pharmacy supplied these products to aesthetic practitioners and clinics based in the UK.

People wanting to order aesthetic products or send a prescription to the pharmacy were required to register an account through the website before requesting supplies. The pharmacy did not supply aesthetics products directly to the general public. Only UK based healthcare professionals qualified to prescribe, or employers of healthcare professionals qualified to prescribe were eligible to register for access to the aesthetics prescription service. Once their account was approved, they used the online electronical prescription portal to generate private prescriptions. The prescriber was required to use a unique PIN number to generate the prescription with an advanced electronic signature. The pharmacy permitted other non-prescribing healthcare professionals to register but they could only order a limited range of products such as non-prescription medical devices, skin treatments and consumables. They were also permitted to add a prescribing healthcare professional to their account if they needed to access prescription only aesthetic treatments.

Individuals were required to supply specific proof of their identity when registering for an online account. A check was carried out to verify the information provided and a record of this was kept. The

pharmacy completed a check of the prescriber's registration status to help make sure they were still able to prescribe and did not have any restrictions placed on their registration. And the SI carried out checks of any prescribers that may have had their ability to prescribe withdrawn or restricted due to any hearings or disciplinaries. However ongoing checks were only carried out annually which meant there was a risk that the pharmacy might not identify if a prescriber's registration had lapsed. For example, if they had not renewed it in a timely manner. The risk of this was discussed with the SI and they agreed to review the process. Non-medical prescribers such as nurses and pharmacists, were also required to provide proof of training to show they had completed relevant learning for the provision of aesthetic treatments so the pharmacy could be assured of their competency.

Some steps were taken to identify the risks identified with the aesthetic services. For example, maximum quantities were set for some treatments to make sure supplies were appropriate and not excessive. And multiple prescription requests for the same person in a short period of time were highlighted. The pharmacy also required prescribers to confirm that consultations were being completed face-to-face rather than remotely. One of the pharmacists who mainly worked with the aesthetics service explained how they contacted prescribers directly if there were any clinical queries. Some clinical checks of the private prescriptions were completed, but there was no access to the patient medication record (PMR) in the pharmacist checking area which was in the basement of the premises. This meant they could not easily complete these checks themselves. However, the pharmacist explained that any queries or concerns were highlighted to them by team members assigned the role of labelling the prescriptions, as at this point, they accessed the PMR and any associated records to assess the suitability of the treatment.

The pharmacy had procedures to manage mistakes that happened when dispensing prescriptions. There was a process to record mistakes that had been identified as part of the final accuracy check, also known as near misses. Mistakes were recorded on a paper log and contained details about the error. But the actions taken to reduce the risk of reoccurrence were very similar for all the entries, rather than being specific to each individual error. So, team members may not be able to demonstrate learning from individual events and show they had reflected on the mistakes that had happened. This was discussed with the RP and SI who both agreed that the records could be improved going forwards. Near miss errors were not reviewed which meant common mistakes and emerging trends may not be identified. There were no recent dispensing errors which is when a mistake is identified after a medicine is supplied to the person. The SI explained the recording process that would occur if one happened.

The pharmacy maintained the records it needed to by law. The RP notice was clearly displayed, and the RP record complied with requirements. A private prescription register was maintained and stored the details that were required. Records of the supplies of unlicensed medicines were kept and included details of the person receiving the medicine. Records for controlled drugs (CDs) were maintained and up to date. Running balances were recorded and checked regularly. The running balances of two CDs were checked against the physical stock available and one was found to be incorrect. The SI investigated the discrepancy and was able to correct the record. A certificate showing current professional indemnity insurance was available and covered the services provided.

There was a privacy policy on the pharmacy's website which contained information about how people's data was processed and kept secure. Physical confidential waste was stored separately and disposed of securely. The pharmacists had completed level three safeguarding training and team members were aware of the process to follow if a safeguarding concern was identified.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to safely manage the workload and the services that it provides. Members of the team have the right qualifications for their roles or are enrolled on to a recognised training course. They feel well supported by their colleagues and managers and can raise concerns.

Inspector's evidence

The pharmacy team consisted of five pharmacists, one of whom was the SI, six qualified dispensers, three accuracy checking pharmacy technicians (ACT) and a warehouse team who were responsible for packing orders ready for the courier to collect and deliver. One team member was enrolled on to a recognised medicines counter assistant training course and felt well supported by the pharmacists with their learning. Holidays were planned to make sure there was enough staff cover. The workload appeared to be manageable, and online orders were generally dispatched the same day they were received. Pharmacy team members completed role specific tasks and those involved with the prescription dispensing process were all qualified to do so. Multiple pharmacists usually worked on a daily basis. One was usually working in the main dispensary located in the retail area and the other in the basement area which was used for the aesthetics service. The SI worked most days and supported team members depending on the workload.

Members of the team had completed some training tailored to the aesthetics service. Ongoing training was led by team members interests but there was no formal or structured training plan in place. However, team members received an annual appraisal and expressed any interests in training and development. They were also able to raise any concerns and provide feedback to the SI. Formal meetings with all team members were held every one to two months. They discussed any changes to processes and the performance of the business. An electronic communication application was also used to share any important and urgent information amongst the team members. There were no targets or incentives in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure, and professional environment for the provision of its services. There are several consultation rooms available for the discrete provision of services and if people need to have a private conversation with a member of the team. The pharmacy's website contains useful information about the aesthetic service.

Inspector's evidence

The premises were large in size and split over two floors. The first floor was accessed from the main high street and the retail area was bright and clean. A small dispensary was located behind the front counter and was being used to assemble NHS and some walk-in private prescriptions. A barrier was used to prevent unauthorised access into the dispensary.

Dedicated parts of building were being used for the aesthetics service. This consisted of a first-floor administration area where private prescriptions which had been generated via the pharmacy's electronic prescribing platform for aesthetic treatments and associated products were labelled along with consignment paperwork. And the basement level was used to assemble aesthetic orders and private prescriptions ready for dispatch. This space was also used to package online orders for beauty products which were then delivered to people by courier.

The premises were clean, organised and well lit. It had climate control to help maintain the room temperature at a suitable level. Its team members cleaned the pharmacy daily. The pharmacy had adequate bench space to safely assemble prescriptions. Three consultation rooms were available for people to have a private conversation or receive a pharmacy service. They were all clean and tidy which helped maintain a professional appearance. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible and suitably managed. It obtains its medicines from licensed suppliers and stores them appropriately. And it carries out checks to make sure they are safe to people to use. The pharmacy's aesthetic dispensing service is generally safe, but it sometimes lacks clinical oversight, which means it may not be able to demonstrate that it completes effective checks when it makes supplies.

Inspector's evidence

There was a small step leading to the entrance of the pharmacy retail area with a manual door. Those with mobility issues were supported by team members to access the services they required. The opening hours of the pharmacy were shown on the entrance and people could contact the pharmacy by telephone or email. The pharmacy stocked a wide range of OTC medicines and beauty products, and pharmacy medicines were stored behind the counter to prevent unauthorised access.

Most aesthetic prescriptions were generated using the electronic prescribing function of the pharmacy's website. The system restricted which products each person ordered depending on their registration profile. Generated prescriptions contained all the required information and were allocated to a dedicated team for labelling and consignment labels were also created for the courier company. They also identified any repeat orders and inappropriate quantities which were then referred to the pharmacist. Prescriptions and invoices were also printed so the pharmacy team could refer to these when dispensing. Dispensers selected and labelled the products, and they were passed on to the pharmacists who completed clinical and accuracy checks. Team members signed the dispensing labels when dispensing and checking so there was an audit trail of the team members involved. In some cases, the accuracy check was completed by an ACT. In these instances, the pharmacist completed a clinical check of the prescription, but a record of this was not made. So the pharmacy was unable to demonstrate that this part of the process had been completed. The pharmacist who was checking these prescriptions explained they completed a clinical check of the prescription in isolation and did not always refer to the patient medication record (PMR). They relied on memory to identify any trends or inappropriate prescribing habits. This meant the clinical check may not always be effective.

Once prescriptions had been checked and approved by the pharmacists, they were passed on to the dispatch team. Orders were photographed before they were sealed ready for dispatch. And the packing process was recorded using CCTV. This meant the team could refer to the photographs and videos if there were queries about order quantities or products. Prescriptions were delivered using a tracked 24-hour courier service. Fridge items were packed in specially designed boxes with ice packs to ensure the contents were kept at the required temperature. Aesthetic treatments were not delivered directly to people's homes. Instead, they were delivered to the prescriber or healthcare professional who was responsible for administering the treatment. On some occasions, prescriptions for non-aesthetic topical creams and antibiotics were delivered directly to people for self-administration.

A small volume of NHS prescriptions was dispensed in the main retail area dispensary. 'Dispensed-by' and 'checked-by' boxes were initialled to show who was involved in both processes. Stickers were applied to the prescription bags if a CD or fridge item needed to be added upon collection. And stickers were also used if the pharmacist needed to provide additional advice. Higher-risk medicines were

routinely highlighted so that people were given advice on how to take them safely. Team members were able to correctly explain the advice they would give to people taking valproate, topiramate and isotretinoin containing medicines. Educational material was also supplied when dispensing these products. Team members working on the front counter were observed asking the name and address before medicines were supplied and were aware of the 28-day expiry for CD prescriptions.

Some pharmacy services were provided including the NHS Hypertension Case-Finding service, seasonal flu vaccination and a paid for phlebotomy service. Team members delivering these services were all trained and appropriate equipment was available to enable them to provide these services safely and effectively.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. Its team members checked the expiry dates of medicines on a rolling basis and a record was made. The expiry dates of some medicines were checked, and none were found to be expired. CDs were stored in a secure cabinet and medicines that required cold storage conditions were stored in a suitable fridge. The temperature of the fridge was seen to be in the required range and the pharmacy kept a daily record of the temperatures. The pharmacy received drug alerts and safety recalls by email. Its team members checked the pharmacy for any affected stock and made a record of the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. It is uses them in a way to help protect privacy. And electrical equipment is regularly tested to make sure it is safe to use.

Inspector's evidence

The pharmacy team used the internet to access websites for up-to-date information, for example, the BNF. All electrical equipment appeared to be in working order and had been PAT tested in March 2024 for safety. There was a selection of clean liquid measures with British Standard and Crown marks. The pharmacy had clean equipment for counting loose tablets and capsules, including tablet triangles.

Four fridges and two freezers were available to appropriately store medicines and cold packs respectively. There was a process in place to rotate the cold packs so that they had sufficient time in the freezer to be able to maintain the cold chain temperature during transit. 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.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. Cordless telephones were available and were used to hold private conversations with people when needed.

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.