General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lips Battersea Pharmacy, 349-351 First Floor, Turbine Hall B, Battersea Power Station, London, SW11 8DD

Pharmacy reference: 9012343

Type of pharmacy: Community

Date of inspection: 18/09/2024

Pharmacy context

This private pharmacy is located next to a clinic within Battersea Power Station. The pharmacy opens seven days a week. It sells medicines over the counter. And it dispenses people's prescriptions. People can visit the pharmacy to have a health check or their blood pressure measured. They can see a pharmacist for advice on immunisations, minor illnesses, vaccinations and weight management.

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	Good practice	2.4	Good practice	Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. And they use their judgement to make decisions about what is right for the people they care for.
3. Premises	Good practice	3.1	Good practice	The pharmacy is well designed to meet the needs of the people who use it.
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 manages its risks appropriately. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make to learn from them and to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

People who worked at the pharmacy understood what they should do if the pharmacy needed to close. They also knew what to do to make sure people could access the care they needed if the pharmacy could not provide a service or open. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were recently reviewed by the superintendent (SI) pharmacist. The pharmacy kept an electronic record to show when a team member had read the SOPs and agreed to follow them. It had a notice that told people who the responsible pharmacist (RP) was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They knew they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't 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 had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). And its team discussed and recorded the mistakes it made to learn from them and help stop the same sort of things happening again. The pharmacy offered a face-to-face consultation and prescribing service. It had risk assessments, suitable equipment and professional indemnity arrangements in place for this service. Its pharmacist prescribers were appropriately trained and routinely kept records for each consultation. But the governance of the prescribing service was being reviewed and strengthened. And, for example, a standardised consultation template had recently been developed to help capture clinical information and prescribing decisions more easily. The SI gave assurance that there would be regular audits to assess the quality and safety of the prescribing service, and consideration was currently being given to who should undertake these.

The pharmacy had a complaints procedure. People could share their views and make suggestions about how the pharmacy could do things better. Some patients have left online reviews about their experiences of using the pharmacy. And, following people's feedback, the pharmacy has applied to the NHS for it to provide NHS services. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept a log to show which pharmacist was the RP and when. It had an electronic controlled drug (CD) register. And the stock levels were checked regularly. But the CD register it used prior to the electronic register hadn't been closed. And the address from whom a CD was received from and the headings on each page of this register weren't completed in full. The pharmacy hadn't supplied any unlicensed medicinal products since it opened. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But its team was reminded that only a certain number of days treatment could be supplied

to a person in an emergency.

The company that owned the pharmacy was registered with the Information Commissioner's Office. And its website told people how their personal information was gathered, used and shared by the pharmacy and the pharmacy team. People using the pharmacy couldn't see other people's personal information. And arrangements were in place to make sure confidential information was stored and disposed of securely. But people's details weren't always crossed out or removed from the unwanted medicines returned to it before being disposed of. The pharmacy had a safeguarding procedure. Its team members needed to complete safeguarding training. And they knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has the people it needs to deliver safe and effective care. And its team members do the right training for their roles. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. And they use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback on how to improve the pharmacy's services. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of three pharmacists, a dispensing assistant, for trainee dispensing assistants and a product specialist. The pharmacy depended upon its team or locums to cover absences. The people working at the pharmacy during the inspection included the RP, the SI, a trainee dispensing assistant and the product specialist. The SI was responsible for managing the pharmacy and leading its team. And the RP supervised and oversaw the supply of medicines and advice given by the pharmacy team.

People who worked at the pharmacy completed induction training when they started at the pharmacy. They also needed to do mandatory training, such as health and safety, during their employment. And they were required to complete accredited training relevant to their roles after completing a probationary period if they hadn't done so already. An assurance was given that the product specialist would be enrolled upon a medicines counter assistant training course. So, they could support the team and help people using the pharmacy. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

Members of the pharmacy team could discuss their development needs with their manager when the pharmacy wasn't busy. And they could complete training to keep their knowledge up to date. The pharmacy had a culture that encouraged its team members to be open and honest about the mistakes they made so they could do things better. This meant it could improve the safety of the services it offered. Members of the pharmacy team didn't feel that any targets or incentives stopped them from making decisions that kept people safe. They worked well together. They helped each other make sure people were seen to as quickly as possible and services were delivered safely. And they were up to date with their workload. Team members knew the pharmacy had a 'duty of candour' policy. They knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And, following their feedback, the security arrangements at the pharmacy were strengthened.

Principle 3 - Premises ✔ Good practice

Summary findings

The pharmacy is bright, clean and modern. It provides a safe, secure and professional environment for people to receive healthcare in. It's well designed to meet the needs of the people who use it, and to make sure they can receive services in private when they need to.

Inspector's evidence

The pharmacy was separate from the clinic. And individual key cards provided assurance that only approved team members and other key personnel had access to the pharmacy. The premises were air-conditioned, bright, clean, modern and secure. They were well laid out and organised. They were professionally presented throughout. And their fixtures and fittings were of a high standard. The pharmacy had two consulting rooms, a counter, an enclosed dispensary and a retail area. It had the workbench and storage space it needed for its current workload. And an additional entrance was installed to help people access it from the clinic next door. The consulting rooms were available for services that needed one or if someone needed to speak to a team member in private. They were locked when they weren't being used. So, their contents were kept secure. And people's conversations in them couldn't be overheard outside of them. The pharmacy had the sinks it needed for the services its team delivered. It had a supply of hot and cold water. And its team and a cleaning contractor were responsible for keeping its premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. And it keeps adequate records for the services it provides to show that it has given the right product to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy was located on the first floor of Battersea Power Station. Its entrance was wide and level with the walkway outside. And this walkway could be reached by escalators, lifts or stairs. This made it easier for people to access the pharmacy and its services. The pharmacy had a small seating area for people to use if they wanted to wait. And it had a digital display in one of its windows which told people what services it offered. Members of the pharmacy team were friendly and helpful. And they took the time to listen to people. So, they could help and advise them, and signpost them to another provider if a service wasn't available at the pharmacy.

The pharmacy was due to start offering immunisations and vaccinations soon. And the pharmacists needed to complete appropriate training before they could administer these. The pharmacy had the anaphylaxis resources and the risk assessments, patient group directions (PGDs) and processes it needed for these services. The pharmacy offered face-to-face weight management consultations, advice and treatments. The RP demonstrated that a recent supply of a weight loss treatment was made through a PGD. And the pharmacy kept a record to show the right product had been given to the right person who had provided their consent for the treatment. The team members who were responsible for making up people's prescriptions kept the dispensing workstations tidy. But medicines weren't assembled until a pharmacist assessed the clinical appropriateness of a prescription. Team members used baskets to separate each prescription and medication. They referred to the prescription when labelling and picking medicines. They scanned the bar code of each medicine they selected, to check they had chosen the right product. And medicines weren't handed out until they were checked by an appropriately trained team member. The pharmacy used a patient medication record (PMR) system which maintained an electronic audit trail of the person responsible for each stage of the dispensing process. And the PMR system helped its team better manage its workload and deal with prescription queries in general. The pharmacy used reminder stickers to alert the team member if a CD or a refrigerated product needed to be added to someone's prescription or if extra counselling was needed.

Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. They were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack. And they had access to the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team usually marked the containers of liquid medicines with the date they opened them. They checked the

expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These things helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. It stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And a team member described what actions they took and demonstrated what records they made when the pharmacy received an MHRA medicines recall.

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 it uses is suitable for what it's being used for.

Inspector's evidence

The pharmacy had some glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out or count medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact a pharmacy leadership body to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team checked and recorded the refrigerator's maximum and minimum temperatures on the days the pharmacy was open. The pharmacy had suitable equipment for the services it provided including health checks and measuring a person's blood pressure. And this equipment appeared to be well maintained. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. It restricted access to its computers and PMR system. And only authorised team members could use them when they put in their password.

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.