

# Registered pharmacy inspection report

**Pharmacy Name:** Click2pharmacy, 33 Werneth Hall Road, OLDHAM,  
Lancashire, OL8 4BB

**Pharmacy reference:** 1033781

**Type of pharmacy:** Community

**Date of inspection:** 06/02/2023

## Pharmacy context

This busy community pharmacy is located in a residential area. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy also has a private prescribing service which people can access from its website [www.click2pharmacy.co.uk](http://www.click2pharmacy.co.uk). It is a pharmacist led prescribing service, so it is not regulated by the Care Quality Commission (CQC). The pharmacy sells a range of over-the-counter medicines which people can purchase in person from the pharmacy or via the website. People can visit the pharmacy for other private services such as travel vaccinations, blood tests and ear wax removal.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Overall, the pharmacy's working practices are suitably effective. It completes the records that it needs to by law. And it asks its customers for their views, and it is responsive to feedback. The pharmacy team understands how it can help to protect the welfare of vulnerable people and it keeps people's private information safe. But the pharmacy does not always proactively identify risks associated with its online services to make sure it manages these in advance of services being introduced. And it could do more to complete audits and reviews, to demonstrate and make sure the online prescribing service systems and processes are safe.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the NHS services which contained signatures showing that all members of the pharmacy team had read and accepted them. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. There were a new set of SOPs which had been prepared in December 2022, but these had not yet been signed by staff, and they did not cover some of the private services which had been recently introduced. So team members may not always work effectively or fully understand their roles and responsibilities. The RP explained that the pharmacist superintendent (SI) was currently working on the SOPs and risk assessments for the private services, which was why they were not on the premises. Following the inspection, the SI confirmed that these had been completed and provided copies. Some of the pharmacy team members were wearing uniforms, but nothing to indicate their roles, so this might not be clear to members of the public. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

There was a SOP for dispensing errors and near misses. The pharmacy team reported dispensing incidents electronically and learning points were recorded. For example, when a person was given the wrong type of insulin, 'always get a double or triple check' and 'keep the fridge clutter-free and tidy' had been recorded as the actions taken to prevent a similar incident occurring again. Near misses were discussed within the team but they were not always recorded. The pharmacy used an automated dispensing robot. A dispenser entered the details of the prescription and attached the medication labels to the packs selected by the robot. A pharmacist then carried out clinical and accuracy check. A dispenser said dispensing errors were less frequent since the robot's introduction, but occasionally errors occurred when the robot's 'mapping' was incorrect. These errors were picked up by the dispensers when they were adding the medication label, and the was mapping corrected to avoid reoccurrences.

The pharmacy supplied prescription only medicines (POMs) and over the counter (OTC) medicines to people living in the UK through its website. People were required to set up an account when they started using the pharmacy's online services. Postcodes were manually checked for duplicate accounts, and medicines would only be supplied to people's billing address, so that there was a cross check of their name and address to their payment card details. The person's previous order history was checked by the prescriber and pharmacy team to ensure any inappropriate requests were identified. The system did not flag repeat or multiple requests automatically, so there was a risk that some issues might be missed. Patient identity (ID) was checked for all oral POMs, as the prescribers considered these at highest risk. ID was verified by the person uploading a photograph of their passport or driving license. A

utility bill could be uploaded as proof of address. The RP said they had considered using a third-party identity checking service, but this had not yet been introduced. Following the inspection, the SI confirmed that they had started requesting photographic ID for all POMs.

The pharmacy supplied over the counter (OTC) medicines for a range of minor ailments. People wishing to purchase pharmacy (P) medicines were required to answer some questions which the pharmacist reviewed before approving the supply. Records of sales were recorded for each customer, so patterns could be monitored. The pharmacy sold high-risk P medicines such as pain killers containing codeine, and sedatives, which were known to be overused and misused. Information about addiction was supplied with codeine containing products. There was a quantity restriction of one pack for pain killers containing codeine and repeat requests were not allowed for three months. Examples were seen of refunds being made when people had re-ordered within three months and an explanation was given to the person, and they were referred to their GP, if they were wanting to take the medicine for long term use. People were asked their age as part of the process when requesting P medicines. The age and ID of people requesting P medicines was not verified which may be a safeguarding risk for some medicines, and under-age people might be able to obtain medicines. Following the inspection, the SI advised that photographic ID would be requested for all OTC medicines containing codeine, going forward.

POMs were supplied against private prescriptions issued by two pharmacist independent prescribers (PIPs) following the completion of an online questionnaire. The two PIPs were both directors of the pharmacy and they both worked at least two days each week at the pharmacy as RP. One of the PIPs was the SI. Prescriptions issued covered a wide range of medicines but were mainly high strength fluoride toothpastes, antibiotics for acne (doxycycline, lymecycline and tetracycline), antibiotics for urinary tract infections (nitrofurantoin), and injections for weight loss (Saxenda and Ozempic).

The online consultation was set up so that it was clear which answer would prevent the supply of the medicine. The person was then allowed to change their answer without any record of the change being made. So, neither the pharmacy team nor the prescriber knew that the incorrect responses had previously been entered. This was a risk because people might accidentally or deliberately enter incorrect information in order to receive a supply. And some higher risk medication, such as antibiotics, could be ordered for indications other than those listed by circumnavigating responses on the online questionnaire. The online consultation was changed immediately following the inspection. All 'blockers' which previously highlighted to the person what responses would lead to a rejection had been removed.

The SI provided comprehensive risk assessments for the clinical conditions it provided prescribing services for. The prescribing policies were underpinned by The National Institute for Health and Care Excellence (NICE) and other evidence based clinical guidelines. The risk assessments identified operational risks associated with using a questionnaire-based consultation method, such as people potentially setting up duplicate accounts and submitting duplicate orders and measures had been put in place to mitigate these risks. The risk assessments combined with the pharmacy's prescribing policies appropriately reflected clinical risks for each condition. For example, there were clinical justifications for the request of medicines for the conditions based on the history of the presentation and relevant exclusion criteria based on precaution or red flag symptoms. Follow up phone calls for all oral antibiotic requests and weight loss medication were made by the prescribers and these were recorded. Consultations could not proceed for certain higher risk conditions without consent to access Summary Care Records (SCRs) and to notify a person's GP. Medication for asthma could not be processed unless a person had documentation on their SCR which demonstrated that there was an asthma plan in place, their annual review was not overdue, and they were on a regular preventer inhaler. The prescribing policies and risk assessments considered the issues of having the same pharmacist responsible for the

prescribing process also being involved in final the clinical and accuracy checks. The pharmacy had separated the functions of the prescriber pharmacist from the functions of the RP. This ensured that the prescriber pharmacist was not the pharmacist undertaking both the clinical and accuracy checks.

The pharmacy could not provide evidence of any internal or external audits of its prescribing service, but there were plans in place to have an external medical doctor audit sample sizes of their popular services to determine the quality of their consultations, documentation and decision making. The SI advised that he was setting up an internal auditing process which would check that the pharmacy was complying with its own prescribing policies and risk assessments.

A notice was on display in the pharmacy with the pharmacy's complaint procedure and the details of who to complain to. This information was also available on the website. People were encouraged to leave feedback using Trust Pilot for the online service. The SI had contacted a number of patients who had used the weight loss service to ask for their input when deciding how best to verify people's BMI, and updated the pharmacy's prescribing policies as a result.

A current certificate of professional indemnity insurance was on display in the pharmacy. The RP confirmed that the insurance providers were aware of the additional services the pharmacy carried out including the online prescribing service, and their insurance arrangements covered them.

Private prescription records were maintained electronically, but the prescriber had not been accurately recorded on some of the prescriptions checked, which could cause confusion. The pharmacy kept a record of all patient consultations and interventions on its own internal systems. However, they did not always record if SCR had been accessed. It kept records for the refusal of medication requests and communication with a person's GP. The RP record appeared to be in order. The controlled drug (CD) registers were electronic. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct.

Members of the pharmacy team had an understanding about confidentiality. Confidential waste was stored in a designated bin inside the pharmacy until it was collected by a waste disposal company. A dispenser correctly described the difference between confidential and general waste. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR).

There was a safeguarding SOP, and a notice was on display with the contact numbers of who to report concerns to in the local area. The pharmacists had completed level 2 training on safeguarding. One of the dispensers confirmed he had received training on safeguarding and said he would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy's team members have the right qualifications for the jobs they do, and they get some ongoing training to help them keep up to date. The pharmacists have the necessary knowledge, skills, and experience to deliver the prescribing services. The team members work well together, and they are comfortable providing feedback to their managers.

### Inspector's evidence

There was an RP, three NVQ2 qualified dispensers (or equivalent) and a trainee dispenser on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and people who visited the pharmacy. The RP was one of the PIPs. A regular locum pharmacist worked one day a week at the pharmacy.

Members of the pharmacy team carrying out the services had completed appropriate training. The trainee dispenser confirmed that he was provided with training time during working hours, and he also completed some coursework in his own time. The rest of the pharmacy team did not have regular protected training time, and there was no structured ongoing training for them. Team members received feedback informally from the two regular pharmacists. Informal meetings were held where a variety of issues were discussed, and concerns could be raised. A dispenser said she felt would feel comfortable talking to either of the regular pharmacists about any concerns she might have. There was a whistleblowing policy.

Both PIPs had comprehensive learning portfolios which covered the breadth of the services the pharmacy currently provided. They had undertaken extra courses for the acute management of illness, specialist weight loss training which covered injectable medication, chronic condition management, the careful handling of antimicrobials and topical treatments. And had undertaken training and supervision for ear syringing and microsuction of the ear, phlebotomy and canulation. Both PIPs had experience working in out-of-hours urgent care settings and the main prescriber regularly worked in general practice. The PIPs had testimonials from a number of medical doctors working in general practice and out-of-hours setting attesting to the competency, quality, and experience of the prescribers. The pharmacists had access to medical peers who they could contact for support and some of these medical peers were involved in formulating the pharmacy's services. A dispenser assistant had completed the course and practical skills for phlebotomy services.

The RP was empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said targets were not set for services and no pressure was put on team members or locum pharmacists to achieve targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has private consultation rooms that enable it to provide members of the public with the opportunity to receive services in private and have confidential conversations. The pharmacy's website has useful information about its services, but the design and content could be improved to promote a more professional image.

### Inspector's evidence

The pharmacy premises, including the shop front and fascia, were reasonably clean and well maintained. The retail area was free from obstructions, professional in appearance and had a waiting area with four chairs. The temperature and lighting were adequately controlled. Staff facilities included a WC, with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks.

There were two consultation rooms. The availability of the rooms was highlighted by a sign on the doors. These rooms were used when carrying out services such as ear wax removal and phlebotomy and when customers needed a private area to talk. The main consultation room used by the pharmacy was equipped with a sink. It was quite cluttered which detracted from its professional appearance. There were sharps bins in both consultation rooms, which were accessible from the retail area. These were health and safety hazards. Paperwork containing confidential information were stored in one of the consultation rooms, risking breaching patient confidentiality. The RP said he was considering obtaining a lockable cupboard to use for storage in the consultation rooms as the rooms were not lockable.

The name and physical address of the pharmacy and the GPhC registration number was displayed on the website. The website gave the names of the PIPs, but it did not make it clear that they were the prescribers for the online prescribing service, so people might not have enough information to make an informed decision about their care. Under each condition on the website the different names of products were shown and their prices. There was the option to enter a quantity and then start a consultation from the individual medicine which gave the impression that the person could choose the specific medicine they wanted to buy, before starting the consultation. This means people may not always receive the most suitable medicines for their needs. The website sometimes used inappropriate transactional language such as, 'add to basket' which gave the impression people were purchasing medicines rather than accessing a healthcare service. This detracted from the professional image of the website and could encourage the inappropriate use of medicines. The website layout was changed immediately after the inspection. Consultation forms were removed from all POMs product pages so people were taken back to the condition page to start a consultation which was in line with GPhC guidance.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy offers a wide range of healthcare services, which are generally well managed and easy for people to access. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply. The assembly of multi-compartment compliance packs could be managed more effectively to minimise errors and make sure people receive all the information they need to take their medicines safely.

### Inspector's evidence

There was a couple of steps up to the front door of the pharmacy, which made it difficult for people with mobility issues and wheelchair users to enter the pharmacy. Staff said they would always be ready to serve customers at the door if necessary. Services were advertised inside the pharmacy and on the pharmacy's website. Notices were on display in the pharmacy advertising its travel clinic, blood testing service and ear wax removal service. There was a small range of healthcare leaflets. Health information was available on the website with links to NHS websites. The SI also posted blogs and tweets. Some of the staff were multilingual, speaking Urdu as well as English, which helped some of the non-English speaking people in the community.

The pharmacy offered a repeat prescription ordering service for patients from the GP practices which allowed it, and people were contacted before their prescriptions were due each month, to check their requirements. This was to reduce stockpiling and medicine wastage. There was a home delivery service. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. There was an associated audit trail which was accessible via an App on the mobile phone used by the delivery driver, but the only way to access this information was via the phone so it wasn't possible whilst the delivery driver was away from the pharmacy which might cause delays in responding to problems and queries.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. The pharmacists added notes to prescriptions to highlight when counselling was required. The team were aware of the valproate pregnancy prevention programme. Original packs were dispensed when possible and the valproate information pack and additional care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

The pharmacy assembled a large number of multi-compartment compliance aid packs. This activity was generally well organised, but the packs for people receiving their medicine on a weekly basis were routinely assembled in advance of prescriptions, from master sheets. These were then checked against the prescriptions when they arrived. This increased the risk of errors and was not in line with the SOP. The master sheet was amended when changes were made to the packs, but it was not always clear who



had confirmed the changes or the date they had been made, which could cause confusion. Cautionary and advisory warnings were missing from the labelling sheets and packaging leaflets were not usually included, so people might not know how to take their medication safely. The dispenser who managed the compliance aid packs confirmed that he would make the adjustment to the labelling to ensure it contained all the required information. An informal assessment was carried out by the pharmacist as to the appropriateness of a compliance aid pack, or if other adjustments might be more appropriate to the person's needs, prior to commencing this service, however this was not recorded. Disposable equipment was used.

The trainee dispenser explained what questions he asked when making a medicine sale in the pharmacy and knew when to refer the person to a pharmacist. He was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if he suspected a customer might be misusing medicines such as a codeine containing product.

People requesting POMs from the prescribing service were asked a series of questions and their responses were reviewed by the prescriber before they issued a prescription, and the supply was made. The consultation questionnaire responses could be viewed by both the pharmacy and the prescriber. The prescribers often contacted the patient by telephone and details of these calls were recorded on the patient's notes. Everyone requesting a prescription for weight loss, antibiotics or asthma inhalers were telephoned by one of the prescribers and the details of these consultations were documented. Examples of interventions were seen such as a person who ordered 3 months of Orlistat shortly after they had just received 3 months' supply. The pharmacy was still awaiting their response. A male patient ordered trimethoprim and after a telephone consultation it was established it was for their partner, and changes were made to the order accordingly. Two examples were seen when people were refused second supplies of antibiotics and referred to their GP for follow-up treatment as their symptoms hadn't improved.

The pharmacy was able to access patient's SCR's with the patients' consent. Patient consent to access SCR's was requested in all POM questionnaires and was mandatory. An example was seen of a refusal to supply asthma inhalers because the person's SCR did not show that they had received a recent asthma review, and they were not on a preventer inhaler. The person was signposted to their GP. Another example was seen when a person was requested to provide evidence that they had been previously prescribed an asthma inhaler and the request was refused when this was not received. Another example was seen when a patient had provided photographic evidence of a previous NHS prescription and the supply was allowed. Following the inspection, the SI stated that they were considering stopping the supply of salbutamol inhalers, as the checks were so time consuming. Consent to share information with the person's GP was requested and was mandatory for some conditions such as asthma and acne. It was not mandatory for weight loss, but during the telephone consultation, the prescribers always stressed the importance of sharing information with their GP and strongly encouraged this. Examples were seen of emails being sent to people's GPs who had provided their GP practice details. A photo was required to be uploaded for people requesting antibiotics for acne. People could communicate with the pharmacist and staff via the telephone or by email.

Physical examination and face-to-face consultation were not part of the process when prescribing weight loss products. People were required to enter their BMI, or weight and height, as part of the weight loss consultation, but there was no verification that the information entered by the person requesting the medicine was correct, and there was a possibility people might try circumvent the system in order to obtain a supply which may not be clinically appropriate. This could mean vulnerable people may be able to obtain medicines which might not be suitable. A question was asked about eating disorders in the weight loss consultation, and this was asked about during the telephone

consultation, to ensure people had understood the question and answered it honestly. Subsequent to the inspection, the pharmacy updated their policy for weight loss medication to request each person submit their waist circumference and a photograph or video evidence showing a portrait of their body shape with an appropriate date stamp or holding the order number. This would be matched against their photographic ID. This was introduced to further safeguard supplies to vulnerable people and to ensure that the medication was only being issued to people who fulfilled the clinical criteria. The pharmacy supplied Ozempic for weight loss. This was not a licensed indication. The prescribers informed people of this during the telephone consultation where they also explained the mechanism of action and side effects. An example was seen of someone who was refused Ozempic 1mg because it was the first time they had used it, so the risk of side effects for this strength was higher. The SI confirmed that Ozempic would no longer be supplied when a licensed version became available.

The pharmacy team used printed copies of the private prescription when assembling medicines. This activity was carried out during the afternoon by a designated dispenser. When they had been checked by the pharmacist, they were packed up in cardboard boxes or envelopes. These were posted on a 24-hour Royal Mail service which could be tracked by the pharmacy. Medicines requiring cold storage, such as Saxenda and Ozempic were packed with special ice packs and bubble wrap to ensure their integrity during transit.

CDs were stored in a CD cabinet. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Patient returned CDs were destroyed using denaturing kits. There was a large quantity of patient returned CDs in the CD cabinet which had not been recorded when returned. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain stock medicines. Most medicines in the pharmacy were stored in their original containers in the robot. Stock was date checked prior to loading into the robot and medicines with an expiry date of less than 6 months were not placed in the robot. Medicines which had not been used for more than six months by the robot were identified as possibly short-dated and could be removed for inspection. Other stock in the pharmacy was date checked periodically, but this was not always recorded. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received electronically. These were read and acted on by a member of the pharmacy team and a record made of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe, and they use it in a way that protects privacy.

### Inspector's evidence

The pharmacist could access the internet for the most up-to-date information for reference. For example, the electronic British National Formulary (BNF) and BNF for children. There was a clean medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. The automated dispensing robot was serviced annually, and a maintenance contract was in place. The team had access to a 24-hour helpline if any problems occurred.

There was a selection of clean glass liquid measures with British standard and crown marks. A separate measure was marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. The pharmacy had the necessary equipment provided by reputable providers for the services. Pharmacy team members had access to anaphylaxis kits, cleaning equipment, sharps bins and clinical waste disposal for the ear wax and phlebotomy services it delivered. It also had calibrated tympanic thermometers, blood pressure machines, stethoscope, and pulse oximeters.

Computer screens were positioned so that they were not visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

## What do the summary findings for each principle mean?

Finding	Meaning
✓ <b>Excellent practice</b>	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.
✓ <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.