General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M.E.J. Hingley & Co Ltd., 560-562 Green Lane, Small Heath, BIRMINGHAM, West Midlands, B9 5QG

Pharmacy reference: 1038007

Type of pharmacy: Community

Date of inspection: 31/08/2023

Pharmacy context

This pharmacy is located on a busy main road in the Small Heath area of Birmingham. Although open to the public, it does not hold an NHS pharmacy contract and the pharmacy's primary business is its online private prescribing service which it offers via its website www.pharmacydirectgb.co.uk, in partnership with a Romanian-based prescriber. The prescribing service covers a range of lifestyle medicines including treatments for erectile dysfunction and hair loss. In addition, general sales list and pharmacy medicines are sold through the website. The pharmacy has a small range of medicines available for sale on the premises, as well as other household goods.

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	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

Members of the pharmacy team follow written procedures to make sure they work safely, and they protect people’s private information. The pharmacy uses risk assessments to help make changes or improvements to the services and the way the pharmacy operates.

Inspector's evidence

People could purchase over the counter medicines, or they could select the condition they required a treatment for and complete an online questionnaire consultation to request a prescription only medicine (POM). People could express a preference for a specific POM towards the end of the online questionnaire. The responses and preference were reviewed by the prescriber before a prescription was issued. The prescriber was a doctor based in Romania. This meant the prescribing service was not registered with a UK healthcare regulator. So, it was not subject to inspection by a UK regulator, such as the Care Quality Commission (CQC) in England, Healthcare Inspectorate Wales or Healthcare Improvement Scotland (HIS) to ensure the prescriber was working in accordance with the standards expected in the UK.

Various risk assessments had been carried out in 2022 when the website had last been updated and the medicines available had been reviewed. The SI said that the risk assessments were due to be reviewed and the timing would be aligned with further website changes. The prescribing service was required to complete specific checks including reviewing the person's ordering history and their date of birth. The prescriber rejected an order if they did not have this information available. People who were in possession of a valid private prescription issued elsewhere could submit the details to the pharmacy and then send the original prescription to the pharmacy to be dispensed.

The pharmacy had a set of standard operating procedures (SOPs) in place. Team members had signed the procedures as evidence of their training and the procedures had been dated to show that they had been recently reviewed. The SOPs were based on templates from a recognised supplier and some amendments had been made to reflect the online services provided. The prescription only medicines available through the online prescribing service were ‘lifestyle medicines’ which had been chosen as they were lower risk than some others and did not require any ongoing monitoring. The online questionnaire had been developed by the SI, with input from the prescribing service, so that they were both satisfied with the questions being asked. The pharmacy team had access to the responses that the person gave to the online questionnaires and routinely reviewed the responses as part of the clinical check. The pharmacy team informed the person if the prescriber had not approved a request for a prescription, and then issued them a refund. Communication with the person usually occurred by email and the pharmacy team were the point of contact if the person had a query about their prescription. For example, the prescriber had rejected a person’s request as it was ‘too early’, however, the pharmacy team investigated and found that the previous request had also been rejected as the prescriber was missing some information and the patient was ordering again with the missing information included.

The pharmacy's telephone number was clearly published on the website. The 'contact' section had the telephone number, email address, physical address and an online messaging form. The invoice that was sent with the order, and the dispensing label for prescriptions also contained the pharmacy's contact

details. A dispensing assistant explained that she was unaware of any errors or concerns in recent years and explained the process that was followed if the pharmacy was to be contacted about an error or complaint.

The pharmacy had up-to-date professional indemnity insurance which covered online activity and prescribing services. The responsible pharmacist (RP) notice was clearly displayed in the shop area and the RP log met requirements. Private prescription records were maintained in a record book and appeared to be in order: each had a reference number which allowed the team to quickly cross-reference to the printed copy of the prescription form that they had dispensed against. Additional records, such as delivery tracking, back up paper records for deliveries, failed/returned deliveries, and rejected orders were also kept.

The privacy policy was displayed on the website and the company was registered with the Information Commissioners Office (ICO). Confidential waste was separated and was disposed of securely.

The pharmacy team members were aware that codeine-based medicines could be abused, misused or overused. They checked the information that the person had supplied when they had placed the order, and then cross-referenced their details to the date that they had last placed an order and how.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the current workload and the services that it provides. The pharmacy's team members use their professional judgement to make sure medicines are appropriate for people.

Inspector's evidence

The pharmacy team comprised of the SI, a dispensing assistant and a trainee medicines counter assistant. The trainee medicines counter assistant had been enrolled on an accredited training course and was working through her course materials. Holidays were requested in advance and cover was provided by other staff members as required. Two other pharmacists were available to work at the pharmacy when the SI had other duties to carry out. The RP always worked with the dispenser as she understood the systems that the pharmacy used.

Members of the team were knowledgeable about their roles and discussed these during the inspection. They correctly answered hypothetical questions related to high-risk medicine sales, for both online sales and in person requests. Ongoing training was undertaken by reading pharmacy magazines and literature that was sent to the pharmacy.

The prescriber had provided Diploma certificates and a reference of good standing from an employer. She had previously been registered with the General Medical Council (GMC), but this registration had lapsed in January 2018. The SI had copies of these certificates, and she regularly checked the prescriber's registration with the relevant regulator in Romania, to make sure she was still authorised to prescribe. The prescriber worked for an agency in Romania and the SI regularly spoke with one of the senior prescribers at the agency.

The team worked well together during the inspection and were observed helping each other and moving onto the healthcare counter when needed. The team discussed pharmacy matters on an ongoing basis, rather than waiting for a formal meeting. The pharmacy staff said that they could raise any concerns or suggestions with the SI or one of the other regular pharmacists and felt that they were responsive to feedback. Team members said that they would contact the GPhC if they ever felt unable to raise the issue internally. No targets were set in relation to the prescribing service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for the provision of healthcare services. And its website provides clear and accurate information.

Inspector's evidence

The pharmacy was open to the public for the sale of general household goods and over-the-counter medicines. The premises were suitably maintained. A range of healthcare promotion materials was displayed in the pharmacy.

The premises appeared clean and there were no noticeable trip hazards in public areas. The dispensary had a suitable amount of space. There was adequate lighting throughout the premises and the ambient temperature was appropriate for the storage of medicines.

The online pharmacy business was provided through a website, which was accessible to people at www.pharmacydirectgb.co.uk. The pharmacy address, contact details and GPhC premises registration number were displayed on the home page, along with additional company information on an 'about us' tab. The prescribing doctors' details, plus a link that people could use to check her registration were also displayed. Consultations for the prescribing service were condition based and there were clear notices explaining that the prescriber would make the final decision on which medicine was prescribed. The website offered some treatments for conditions that required monitoring. including asthma and weight loss. These medicines had not been requested by members of the public so the process for this ongoing monitoring was not inspected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services and supplies medicines safely, and people can easily contact the pharmacy. The pharmacy gets its medicines from licensed suppliers, and it stores them securely and at the correct temperature, so they are safe to use.

Inspector's evidence

The pharmacy was located on a busy main road and was accessible via a small step. The pharmacy did not hold an NHS contract and the pharmacy team referred people requesting NHS pharmacy services to nearby pharmacies. The pharmacy website had information on various medical conditions and information on the medicines that were available. Additional health information was available in the blog section of the website.

Dispensing was undertaken on the premises and baskets were used to keep medicines separate and reduce the risk of them being mixed up. The pharmacists signed the 'checked by' box on the dispensing label as an audit trail. And the dispensing assistant undertook an accuracy check as she was packing the medicines for delivery.

A range of OTC and prescription only medicines were available through the pharmacy's website. Prescribing service treatments were available for a limited range of conditions. The conditions and medicines had been reviewed over the past 12-months. The pharmacy team had found that the vast majority of prescription requests were for hair loss and erectile dysfunction treatments.

Requests for general sales list and pharmacy medicines (P medicines) were checked before being approved for supply. Patients selected the medication required, completed an online questionnaire and payment was processed through the website. Once an order was received the dispenser or pharmacist reviewed the request and either approved or rejected the order. The pharmacy sold some medications which could be abused, misused or overused, such as codeine-based pain relief. On the website there were statements which explained that only one box of such a medication could be supplied at a time and the ordering history was checked before the supply was approved, this included orders that had been cancelled. If an order was refused the person was sent an email to explain why, and a refund was processed.

People requesting prescription only medicines were required to complete an online questionnaire. This included providing information such as who the medicine was for, the type of symptoms being experienced and the details of any other medications or health issues. In addition, people provided information such as their weight, height, smoking status, medical history and blood pressure. There were some 'pop-ups' during the online questionnaires which prevented the person from continuing unless the response was changed. The pop-ups were only used to prevent the person continuing with the questionnaire when medication requested was specifically for men, such as erectile dysfunction treatments or treatment for male pattern baldness. Some responses to 'yes or no' questions resulted in a free text box opening. The free type boxes were used for the person to add in extra information about their response for the prescriber. People were also required to upload proof of their identity, such as a driving licence or passport.

Deliveries were sent as standard via a 48-hour tracked service which required a signature upon receipt. At an additional charge, people could request a special next day delivery service. Return address labels were used and the pharmacy kept audit trails of medications which had been supplied. Returns were also tracked and there were special bins for returned medication. People were contacted by email if the medicines that had been prescribed for them was out of stock at the wholesalers.

Stock medicines were sourced from several licensed wholesalers. The stock was organised and remained within the original packaging. Date checking records could not be located on the day, but team members reported that stock was usually used up quickly, and date checks were carried out by the pharmacy team. Short-dated medicines were clearly marked and disposed of prior to going out of date. No out-of-date medicines were identified from random checks. A medicine waste bin was available for the disposal of pharmaceutical waste. No CDs which were subject to safe custody requirements were stored on the premises and very few medicines that required cold-chain storage were supplied. The pharmacy did stock some pharmacy restricted eye drops in the fridge, and the fridge thermometer had broken. The RP agreed to address this immediately after the inspection. Drug alerts were received through an email system and via wholesalers, and these were actioned as appropriate.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And the team uses equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. Computer screens were not visible to the public as members of the public could not access the dispensary. The pharmacy team took phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.