General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy Online / Travelpharm, Manor House, Merlin Way, ILKESTON, Derbyshire, DE7 4RA

Pharmacy reference: 1089485

Type of pharmacy: Internet / distance selling

Date of inspection: 22/08/2023

Pharmacy context

This is a pharmacy which offers its services to people through its websites www.peakpharmacy.co.uk, www.travelpharm.com and www.peakpharmacyonline.co.uk. People do not visit the pharmacy in person. It has a pharmacist-led prescribing service and a wide range of prescription and over the counter (OTC) medicines are available via the websites. The pharmacy also dispenses some NHS prescriptions.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not adequately manage the risks involved with selling high risk over the counter medicines online. It does not complete sufficient checks when selling these medicines. And it does not have effective systems to identify potentially inappropriate supplies.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	One of the pharmacy's websites is arranged so that a person can choose a prescription only medicine (POM) and its quantity before there has been an appropriate consultation with a prescriber.
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 not all met**

Summary findings

The pharmacy manages its NHS services and the online prescribing service reasonably safely. But the pharmacy does not identify and manage all of the risks associated with its online sales of pharmacy (P) medicines to make sure sales are appropriate. And the pharmacy could do more to complete audits and reviews, to demonstrate and make sure the online service systems and processes are safe and effective. The pharmacy team members keep people's private information safe and they generally complete the records that they need to by law. But some of the records are incomplete or inaccurate, which could cause confusion and makes audit more difficult.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided. Some SOPs were specific to the distance selling environment. For example, the transfer to patient SOP. The responsible pharmacist (RP) explained that he and the pharmacist superintendent (SI) were currently reviewing the SOPs to ensure they covered everything required for the online services. The SOPs contained signatures showing that members of the pharmacy team had read and accepted them. But a recently recruited member of the pharmacy team had not yet read and signed the SOPs. Roles and responsibilities were set out in SOPs and the pharmacy team members were generally performing duties which were in line with their roles. The RP was the regular pharmacist and he worked most days at the pharmacy. He was a pharmacist independent prescriber (PIP), and he was the main prescriber for the pharmacy's prescribing service. His name was displayed in the pharmacy, and it was also displayed on the pharmacy's websites. There was a second PIP who prescribed and worked as RP when the regular RP was absent, and there were some occasions when they both worked together.

There was an SOP for dealing with an incident, error or near miss. Near misses were recorded on logs and were reviewed and discussed with the pharmacy team. Actions were taken to prevent similar incidents happening again. For example, by using baskets to separate amitriptyline 10mg from 25mg tablets on the dispensary shelves and attaching pack size alert labels in front of 28 and 100 packs of codeine 30mg, which were in almost identical packaging, and could be easily confused. The pharmacy team reported dispensing errors to the SI's team. The SI team reported them on the National Reporting and Learning System and shared learnings with other pharmacies in the group in a weekly email.

In addition to dispensing NHS prescriptions, the pharmacy supplied prescription only medicines (POMs) and OTC medicines for a range of conditions through its websites. People were required to set up an account when they started using the pharmacy's online services. The pharmacy team made some manual checks to ensure people didn't make duplicate accounts to obtain more medicines. Audits of postcodes were carried out to help identify potential duplicate account. But the last audit had been over six months ago. A person's previous order history was checked by the pharmacy team members when reviewing an order to make sure any inappropriate requests were identified. The system did not flag repeat or multiple requests automatically, so it relied on the team's vigilance. People's identity (ID) was verified for all POMs requests using a third-party identity checking service, which was integrated into the websites. If the person failed the initial ID check, then they were asked to upload a photograph of their passport or driving license. The ID verification process had only been introduced in the last two to three weeks, so prior to this there was a risk people could provide false information to obtain

medicines. People were asked their age as part of the process when requesting P medicines, but their age and ID were not verified. This was a potential safeguarding risk and under-age people might be able to obtain higher risk medicines.

A range of POMs were offered via the websites for malaria prevention, hay fever and allergies, erectile dysfunction (ED), altitude sickness, emergency hormone contraception (EHC) period delay, traveller's diarrhoea, hair loss and jet lag. The RP said they had deliberately chosen conditions which did not require monitoring and didn't involve high-risk POMS. The most commonly prescribed medicines during the previous six-month period were for malaria prevention which accounted for around 70% of prescriptions from the pharmacy's prescribing service.

OTC medicines offered on the pharmacy's websites included high-risk P medicines such as pain killers containing codeine, and antihistamines used as sedatives, which were known to be overused and misused. There was an 'OTC medicines misuse' SOP and risk assessments for selling OTC medicines online. Risks had been identified around inappropriate sales and quantities of medicines, and some maximum limits had been set to prevent customers over ordering. There were restrictions on the quantity of pain killers containing codeine that could be supplied at a time and how frequently repeat requests were allowed. This was outlined in the pharmacy's opiate policy which was available on the pharmacy's websites. The policy encouraged people suffering from addiction to contact their GP or the National Anti-drug Advisory Service (FRANK). Examples were seen of refunds being made when people had re-ordered too soon and relevant signposting information was sent to the person. A sedative policy was also available on the websites which indicated the maximum quantities and frequencies that people could purchase antihistamines such as Phenergan. Publishing the policies with a maximum quantity and frequency of a medicine that a person was allowed to purchase, meant that people knew when to reorder to avoid being under scrutiny, and there was a risk that the pharmacy might miss opportunities to identify people overusing these medicines.

The pharmacy had risk assessments for its prescribing services. These identified the risks and the mitigating actions which would reduce or alleviate the risks. But the risk assessments did not identify the likelihood of the identified risk, and the potential impact before mitigating actions were put in place. And the risk assessments did not identify who was responsible for reviewing the risks and the timeline of when the risks would be next reviewed. The pharmacy had prescribing policies for the services it delivered. The prescribing policies did not confirm how clinical information was verified. For example, how Summary Care Records (SCRs) would be accessed, or a photograph submitted. The policies did not include details on how it confirmed a person's ID and whether it was optional or mandatory to inform the person's usual prescriber. Information on who had reviewed the policy, when it had been reviewed and when the next review was to take place were also missing. The RP prescribed for the online prescribing service as well as carrying out the final clinical and accuracy check on prescriptions. He explained that he prescribed in the mornings and carried out clinical and accuracy checks in the afternoons to help separate the functions. And he said he could request a clinical check by the other PIP or the SI if necessary. But the prescribing policies and risk assessments didn't consider the risks of having the same pharmacist responsible for all these activities. The RP explained that the team were working towards a process whereby the prescribing would be separated from the dispensing process, but this was several months away. The pharmacy did not audit how compliant it was with its own risk assessments and prescribing policies. And there had been no audits of high-risk P medication sales.

There was a SOP for dealing with complaints and the complaints procedure and the details of who to contact about a complaint were available on the websites. People could leave feedback using Trust Pilot for the online services. 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 that

the pharmacy carried out including the online prescribing service, and their insurance arrangements covered them. He said both PIPs had individual professional indemnity insurance to cover their own prescribing.

Private prescription records were maintained electronically, but some details were missing. For example, the name of the prescriber or their address was missing on a small number of entries, which might cause confusion in the event of a query or problem. The pharmacy kept a record of the responses from the online consultations along with notes of any counselling and interventions. Details of phone calls and emails were attached to the person's records. Each PIP had their own log in details and passwords. Electronic signatures were used on prescriptions and the IP address of the prescriber could be checked. The RP log was recorded electronically as part of the patient medication record (PMR) system, but the RP did not record the time they ceased their duties each day, so there was an incomplete audit trail. The RP explained that he had assumed that the system automatically logged him out as he was required to sign in each morning, but he confirmed that he would use a paper record going forward which would be easier to maintain. The controlled drug (CD) registers appeared to be generally in order, although headers were missing from the tops of some of the pages, so there was a risk of making an entry in the wrong register. Records of CD running balances were kept but they were not regularly audited, and a discrepancy was found when a sample of CD balances were checked. This was resolved during the inspection and was due to a missing entry.

There were SOPs on confidentiality and data handling and team members had completed training on information governance and data security. Confidential waste was stored in designated bags until they were collected by a third-party company for disposal. The medicine counter assistant (MCA) correctly described the difference between confidential and general waste. There was a privacy policy and a cookies policy on the websites. The pharmacy was able to access people's SCRs, and the RP confirmed that he sometimes accessed SCRs when necessary to confirm information entered on the online consultation. But consent to access SCRs was not requested during the consultation, so this was a potential breach of the patient's confidentiality. Following the inspection, a question requesting consent to access SCRs was added into the consultation, so consent would be obtained and recorded going forward.

There was a 'safeguarding children and vulnerable adults' SOP. The RP had completed level two and three training on safeguarding. Other members of the team had completed training on safeguarding at levels relevant to their roles. The MCA said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There were several examples seen of people obtaining high risk P medicines liable to abuse and misuse on a regular basis. And supplies had been made to a person who had created multiple accounts in order to obtain more than the pharmacy's opiate policy allowed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team, and the workload is manageable. Pharmacy team members get ongoing training to help them keep up to date and they have opportunities to discuss issues informally as a team. They are comfortable providing feedback to their manager and they receive informal feedback about their own performance.

Inspector's evidence

There was a pharmacist (RP), a pharmacy technician (PT), an MCA and an admin/marketing assistant on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. Absences were covered by transferring staff from neighbouring branches and the SI and deputy SI, who were based at head office, assisted in the pharmacy when required. The RP explained that NHS prescriptions would take priority when workload was high, and the team were stretched.

Members of the pharmacy team used online resources to keep their training up to date. Training records were available for each member of the team, and they had completed a variety of modules including courses on harassment and bullying, contraception, sexual health, healthy living, and equality, diversity, and inclusion (EDI). The SI's team were able to access the training records to see if there were any outstanding training requirements. New members of staff completed induction training and received a review after three months. The pharmacy team received a weekly email from head office which covered a range of topics including the company's performance, patient safety matters, and amendments to SOPs. The admin/marketing assistant had completed training on understanding health improvement and helped with social media and content for the website. He also helped to produce flyers, newsletters, and the weekly email from head office. The assistant occasionally selected P medicines from the shelves and packed them for supply, which he was not qualified to do as he had not completed and was not enrolled onto an MCA course. He said he would always ensure that another member of the team checked the P medicine before he packed them for supply. The RP confirmed that he would review which duties the assistant completed to ensure it was in line with his training and his role.

There was a formal appraisals process where a team member's performance and development were discussed. The RP explained this was supposed to be on an annual basis. He admitted the team were behind with appraisals, but informal feedback was provided, and the pharmacy team discussed issues on a regular basis. Team members described an open and honest culture in the organisation and confirmed that they felt comfortable admitting errors and would talk to the RP about any concerns they might have. There was a whistleblowing policy.

The RP was experienced in prescribing travel medicines, in-particular antimalarials, and he had recently completed a diploma in travel health. He said he had self-declared competency in the other areas he prescribed in, and he read journals and summaries of product characteristics (SPCs) to keep his knowledge up to date. The pharmacy did not document its internal process of training and developing a new PIP's competency to prescribe for the services offered by the pharmacy. But the RP confirmed that the other PIP had similar areas of competency to his own and he had shadowed him whilst he became more experienced in travel health.

The RP felt empowered to exercise his professional judgement and confirmed that he could comply with his own professional and legal obligations. For example, refusing to sell a P medicine containing codeine, because he felt it was inappropriate. The team were not under any pressure to achieve targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises provide a professional environment for the provision of healthcare services. Its websites contain useful information about the pharmacy's services. But one of the pharmacy's websites allows people to select the prescription only medicines and its quantity before having a consultation with the prescriber. This increases the likelihood that people may sometimes receive medicines which are not necessarily suitable for them.

Inspector's evidence

The pharmacy premises were in a closed unit on a mezzanine floor above a large warehouse in a business park. The company's head office was also located in the building. The pharmacy was clean and in a reasonable state of repair. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office and there was an in-house maintenance team. Team members had access to WCs with wash hand basins and hand wash. There was a dispensary sink for medicines preparation with hot and cold running water. Members of the public did not enter the pharmacy and it did not have a consultation room.

The pharmacy's websites contained some information about the pharmacy and its services. The pharmacy's address, GPhC registration number and the prescriber's details were displayed on the websites. The SI's name and registration number was missing from one of the websites (www.peakpharmacy.co.uk). One of the websites (www.peakpharmacyonline.co.uk) was arranged so that a person could choose a POM before there had been an appropriate consultation with a prescriber, and it contained inappropriate wording which could encourage the purchase of POMs such as 'buy online'.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's dispensing operation is well managed. It gets its medicines from licensed suppliers and the team carries out checks to ensure medicines are in suitable condition to supply. The pharmacy has some controls in place to prevent over ordering of medicines. But it could do more checks when supplying some higher risk medicines to make sure that they are appropriate for the people they supply.

Inspector's evidence

Details about the pharmacy's services were stated on the websites. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. For example, travel vaccinations, which were provided by neighbouring branches. Services available in other branches of the company were shown on the websites. This helped to inform people of services and support available elsewhere. On a few occasions the pharmacy provided flu vaccination clinics. These were held off the pharmacy premises. For example, in schools and workplaces. Health information and health campaigns were accessible via the websites, and this included the contact details of support groups. There were blogs such as a recent one on antimicrobial awareness and guides on a range of healthcare topics. For example, antimalarials and other methods of malaria prevention, and advice on stopping smoking. People could communicate with the pharmacist and staff via the telephone or by email. NHS prescriptions were sent to the pharmacy by the Electronic Prescriptions Service (EPS) when people requested that the pharmacy should be their nominated pharmacy. Both NHS and private prescriptions were posted to patients by a 24-hour Royal Mail service which could be tracked by the pharmacy.

People could visit the pharmacy's websites and request a prescription only medicine by filling in an online questionnaire which was assessed by one of the PIPs before the pharmacy supplied the medicine. The prescriber reviewed the answers to the questionnaire, checked the person's previous order history and contacted them by telephone or email if they required any additional information. The RP said that if the pharmacy received frequent requests for EHC, he would signpost the person to their GP and provide them with a sexual health leaflet. He contacted people who requested a variety of different medicines for ED, to ask the reasons why and provide advice if necessary. The RP provided counselling on the use of antimalarial and other avoidance methods as part of the travel service. The pharmacy took some steps to verify the information provided by the person completing the online consultation. For example, a photo was required to be uploaded every three months for people requesting treatment for hair loss. During the online consultation consent to share information with the person's GP was requested, and the RP confirmed that most people did provide consent. But the pharmacy did not inform the person's usual prescriber when they supplied a medicine unless there was a significant issue. This meant that their GP may not have relevant and up-to-date information about the person to support ongoing safe and effective care. And this was misleading as the person receiving the medication could be under the impression that their GP had been made aware of the supply.

People wishing to purchase P medicines online were required to answer some questions. There were also free-type boxes for some of the medicines. The MCA or PT reviewed the answers and checked the person's previous purchase history before approving the supply, but the RP did not have regular oversight of the sales of P meds.

Space was adequate in the dispensary and the workflow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. 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.

The team were aware of the requirements for a Pregnancy Prevention Programme to be in place and that people who were prescribed valproate should have annual reviews with a specialist. The RP explained that the pharmacy did not currently have any patients in the at-risk group. He stated that he would ensure the care card from the original packaging was clearly visible for anyone prescribed valproate, and he would telephone them and provide appropriate counselling if necessary.

CDs were stored in a small CD cabinet which was securely fixed to the wall. The keys were under the control of the responsible pharmacist during the day. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was highlighted. Alerts and recalls were received from various sources including head office. These were printed out, read, and acted on by a member of the pharmacy team and filed. The action taken was recorded so the team were able to respond to queries and provide assurance that the appropriate action had been taken. In some circumstances the team were required to send a confirmation e-mail to head office.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

There was a variety of reference sources including printed versions of Martindale and Stockleys, and the team could access the internet for the most up-to-date information. For example, the electronic British National Formulary (BNF), BNF for children and the Drug Tariff. 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. A temperature logger was also available to provide extra reassurance that the fridge remained within range. All electrical equipment appeared to be in good working order. PMRs were password protected. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs.

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.