General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cameolord Ltd, Oxford House, 16 Oxford Street, MANCHESTER, Lancashire, M1 5AE

Pharmacy reference: 1091123

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

This city centre community pharmacy is situated on a busy main road. It is open extended hours late into the evening, seven days a week. The pharmacy mainly prepares NHS prescription medicines, and it has a busy substance misuse service. The pharmacy sells over the counter (OTC) medicines and it offers other treatments using patient group directions (PGDs) online, via its website www.yourmedsdelivered.co.uk. It also provides PGD treatments following in person consultations in the pharmacy. This inspection primarily focussed on the pharmacy's online services.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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 have adequate systems and procedures to identify and manage risks in relation to selling medicines online.
		1.2	Standard not met	The pharmacy does not review the safety of its online services, or have systems to monitor sales or detect inappropriate requests, particularly in relation to OTC medicines liable to misuse and abuse.
		1.6	Standard not met	The pharmacy's Responsible Pharmacist records are often illegible or incomplete. And it does not have appropriate records relating to online supplies of OTC medicines.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy cannot demonstrate that its staff receive essential training and are suitably qualified for their roles.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website contains inaccurate information about the superintendent pharmacist's identity.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy is not able to demonstrate that the medicines it sells online are safe or clinically appropriate for the people it supplies. The pharmacy does not make clear the pharmacist who is responsible for each OTC medicine that it sells online.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not manage all of the risks associated with its services. It does not have written procedures or keep appropriate records for its online services, so it can show how it supplies medicines safely. And it does not effectively monitor online sales to detect inappropriate requests, particularly in relation to OTC medicines liable to misuse and abuse. In addition, the pharmacy's responsible pharmacist records are illegible or incomplete, so it is not always possible to identify who is responsible for the services.

Inspector's evidence

The pharmacy commenced its online services in December 2023. The superintendent pharmacist was the sole pharmacist responsible for assessing each OTC medicine and PGD treatment request received via the pharmacy's website. No other pharmacy team members, except for delivery drivers, were involved in providing the online services. The superintendent explained that there were no written procedures, risk assessments, identity or age checks for online supplies of medicines.

The pharmacy had professional indemnity insurance in place for its main face-to-face services. The superintendent pharmacist subsequently provided information that suggested the pharmacy's professional indemnity cover included selling OTC and PGD medicines online. However, it was unclear when the online OTC medicine sales cover started.

People selected the OTC medicine they wished to purchase on the pharmacy's website. The website then presented the person with a basic questionnaire intended to check whether the selected medicine was safe and appropriate for them before proceeding to the checkout stage. The pharmacy could not provide any evidence to support that it effectively reviewed responses to these questionnaires or issued appropriate advice to people who requested or purchased medication via its website. The superintendent pharmacist explained that he had not completed any formal reviews or monitoring of the OTC medicines that the pharmacy had supplied online. He recalled that he had noted an increase in opioid-based OTC medicine requests via the pharmacy's website, and he had identified two people who might be abusing them, but the pharmacy did not have an effective system to identify inappropriate requests.

The RP working in the main dispensary supervising the face-to-face services was not displaying their RP notice. However, the RP printed a notice and displayed it when this was pointed out. Recent sections of the RP record were either illegible, or no entry had been made. This meant it was not possible to identify the pharmacist who was the RP on duty at a given point in time, as required by law.

The pharmacy's online sales management IT system was basic and rudimentary, and it was difficult to interrogate. The system had a chronological record of everyone the pharmacy had supplied. But this could not be easily filtered by the person's name, or the medicine requested or purchased, so it was impossible to review. The pharmacy's system did not store people's online OTC medicine purchase history in a manageable format, which meant inappropriate requests could not be easily detected. And the pharmacy did not have any system for recording interventions, including any advice given to people who requested OTC medicines online. This meant that it could not review the quality of the pharmacist's interventions or show that people were provided with appropriate advice.

The pharmacy kept registers of CD transactions. It did not supply any schedule 2 or 3 CDs online. CD register page headings identifying the CD, strength or dosage form were not always included, as required by law. And the pharmacy did not keep a running balance for all CDs, or regularly check existing running balances. This meant the pharmacy team might delay detecting CD stock discrepancies.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy’s staffing arrangements are unclear. And the pharmacy cannot demonstrate that the staff receive the right training for their roles, or are suitably qualified and skilled for the safe and effective provision of the pharmacy's services.

Inspector's evidence

The staff present providing the face-to-face services included the RP, who was a locum pharmacist covering Monday and Tuesday 9am to 6pm, a trainee dispenser who started working at the pharmacy around two weeks ago, and two medicine counter assistants (MCAs) who worked during the daytime Monday to Friday.

The superintendent's office indicated that the pharmacy's other staff included three regular locum pharmacists, the superintendent pharmacist who regularly worked as the RP during the evenings, four MCAs who mostly covered evenings and weekends, and a dispenser who worked Saturdays. The pharmacy shared delivery drivers with other pharmacies under the same ownership.

It was unclear if team members had completed any accredited pharmacy training relevant to their roles. And the pharmacy could not provide any evidence of staff training. None of the pharmacy team members present during the inspection, including the RP, knew about the online service.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy’s website contains inaccurate information and people are not appropriately informed who is responsible for the pharmacy’s services. The premises are clean and suitable for delivering the pharmacy’s services. It has a private consultation room, so people can have confidential conversations with pharmacy team members and maintain their privacy. A separate private area is available for people to access the substance misuse treatment service.

Inspector's evidence

The pharmacy’s website contained inaccurate information about the superintendent pharmacist for Cameolord Ltd. And it did not specify who was responsible for the pharmacy’s online services.

The pharmacy premises was clean and appropriate for the services provided. The shop fittings were suitably maintained. The retail area and counter could accommodate the number of people who usually presented at any one time. The relatively small dispensary provided enough space for the volume and nature of the pharmacy's services. A consultation room was available for private discussions. It was left unsecured and contained an unsealed sharps bin. So, members of the public may be exposed to a health and safety hazard. Substance misuse clients obtained their methadone supply via a private booth that had its own separate external access door.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy is not able to demonstrate that the medicines it sells online are safe or clinically appropriate for the people that it supplies. It does not have sufficient safeguards in place when selling OTC medicines online including those liable to misuse and abuse. The pharmacy generally sources and stores medicines safely. But it does not always complete regular checks to make sure medicines are stored at the correct temperature.

Inspector's evidence

The pharmacy opened from 8am to midnight, seven days each week. It had a step-free wide entrance for easy access. Publicly displayed promotional material in the front window and leaflets listed information about the pharmacy's services and various healthcare topics. The RP confirmed that they were accredited to provide all seven treatments under the NHS Pharmacy First service.

The superintendent pharmacist explained that in relation to the online OTC medicines service, the pharmacy did not have a system to verify people's identity or age. He did not know how to access the pharmacy's systems to review people's online medicine purchase history, and he relied on his memory to recognise the details of people who were repeatedly requesting the same medication via the pharmacy's website. He later confirmed that the pharmacy's online system was not designed to capture people's online purchase history. People were not required to register or create an account so that their previous purchases could be captured and reviewed. This was evident when the inspector was shown the customer management IT system for the online services. This meant that the pharmacy did not have any credible arrangements for reviewing OTC medication it had supplied to people. And people could easily evade the pharmacy's system and make frequent purchases without the pharmacy being able to easily detect inappropriate requests for medicines liable to abuse.

The pharmacy's website allowed people to proceed from checkout with a basket containing several different opioid containing medicines. It also allowed people to place more than one unit of a medicinal product in their basket. The superintendent explained that the system was automated to block these purchases at checkout. However, this could mislead people as they were offered more than one pack of medicines online that are typically for short-term use only.

The superintendent pharmacist stated that he usually reviewed the online OTC medicine requests on his laptop when he was not necessarily working in the pharmacy or acting as the RP. He or office staff then selected the medicines sold online from the pharmacy's stock. Online medicine orders were packed in an office upstairs from the pharmacy and supplied via a delivery service. The pharmacy's drivers delivered to people living locally and a national courier was used to fulfil supplies elsewhere. The pharmacy's website did not state the pharmacist responsible for each OTC or PGD medicine it sold online. So, people were not appropriately informed of the identity of the pharmacist responsible for medicines supplied online.

The superintendent pharmacist stated that people were asked for their GP details. However, they could not provide any records or evidence to support that information or concerns about people's online purchases were shared with their GP.

The superintendent pharmacist confirmed that he was the sole pharmacist authorised for supplying

medicines online under a corresponding PGDs. He explained that the pharmacy typically received up to two online PGD medicine requests each month, and these were usually for urinary tract infection treatments. PGD records did not contain a section for the healthcare professional to complete indicating whether they supplied medication. And the superintendent did not always record their details as the supplying healthcare professional on the PGD records. So, it was unclear who was responsible for each online PGD supply. The superintendent did not have a clear procedure for online emergency hormonal contraception (EHC) supplies, including the delivery arrangements. So, it was unclear if the pharmacy had assessed whether it could supply EHC medication online within appropriate timeframes.

The superintendent pharmacist explained that he checked the patient's NHS National Care Record when he reviewed medications requested under a PGD to help make sure the supply was safe and appropriate. However, there were no records supporting that these checks were completed.

Records of in-person PGD consultations in the pharmacy were not always completed in full. This included obtaining the patient's consent to provide the service and mandatory questions that needed to be answered under the relevant PGD. This meant the pharmacy could not always demonstrate that each PGD medicine supply was safe and appropriate. The superintendent explained that he always asked the mandatory questions on each PGD questionnaire, but he did not always record the responses, but he agreed to address this.

Team members working in the pharmacy explained how they managed in person requests for OTC medicines. MCAs expressed confidence to refuse sales if they suspected people who repeatedly visited the pharmacy to request OTC medicines that were liable to abuse. They advised these people to consult their GP and alerted the RP and other team members to individuals repeatedly requesting these medicines. They confirmed that they monitored requests for these medicines to avoid selling them to the same people.

The MCAs and the RP did not know about the recent legal reclassification of codeine linctus, which meant it should only be supplied via a prescription. During the inspection, the RP subsequently informed the MCAs about the changes and the MHRA's statement, and advised them to cease selling it.

The team prepared methadone supplies in advance of people presenting to receive them. Methadone instalments for more than one day were supplied in divided daily doses. These arrangements helped manage service demand and make sure people took the correct dose of their medication. The pharmacy had the facilities to suitably secure CDs. The team used destruction kits for denaturing unwanted CDs.

Staff members recorded the date they opened medicine stock bottles to help make sure it was supplied in good condition. The team did not know if there were any records of medicine stock having their expiry dates checked. A dispenser explained that they checked the expiry date on medication that the wholesaler had just delivered to the pharmacy and when they were preparing to supply it to people. A few medicines due to expire at the end of March 2024 and April 2024 were found during the inspection amongst several randomly selected stock items. These were quarantined for disposal.

The refrigerator used to store medicines was found to be operating within safe temperature range during the inspection. But records indicated that the team had only monitored medication refrigerator temperatures for a few days during February 2024, which suggested that these temperatures were rarely checked. And staff members, including the RP, did not know how to reset the thermometer, which meant the correct temperatures may not always be checked and recorded. The team agreed to address this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities that it needs for the services it provides. Equipment is appropriately maintained.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. The team had a range of clean measures, including a separate set for preparing methadone supplies. So, it had the equipment to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The RP had access to the British National Formulary (BNF) online, which meant it could refer to pharmaceutical information if 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.