General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newport Pharmacy, The Brown House, High Street, Newport, SAFFRON WALDEN, Essex, CB11 3QY

Pharmacy reference: 1093367

Type of pharmacy: Community

Date of inspection: 16/09/2022

Pharmacy context

This is a local community pharmacy. It is situated on a small parade of local shops and businesses in Newport. It provides a range of services including dispensing NHS and private prescriptions. And it supplies medicines in multi-compartment compliance packs for people who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including a medicines delivery service and a seasonal flu vaccination service. The pharmacy was identified for a targeted inspection after the General Pharmaceutical Council (GPhC) received a concern about its association with an online prescribing service. Following the inspection the pharmacy ceased its relationship with that service and had its name removed from the corresponding website.

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 doesn't do enough to identify and manage the risks associated with the prescribing service it is linked to.
		1.2	Standard not met	The pharmacy doesn't review and monitor the safety and quality of the prescribing service it is linked to and supplies medicines for.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is linked to an online prescribing service which does not comply with general Pharmaceutical Council (GPhC) guidance.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not have the appropriate procedures and policies for ensuring the safe supply of medicines prescribed through the website it is linked to.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't have all the procedures it needs to help make sure the prescribing service it is associated with is safe or effective. And its procedures for identifying and managing the risks associated with the service are inadequate. It doesn't review and monitor the safety and quality of the service. And it doesn't do enough to ensure that the service it uses is keeping people's private information safe. The pharmacy has insurance to protect people if things do go wrong. The pharmacy has adequate written procedures in place for its face-to face activities to help ensure that its team members work safely. And it generally keeps the records it needs to.

Inspector's evidence

The pharmacy had launched its seasonal flu vaccination service on the day of the visit. And the regular responsible pharmacist (RP) who was also the superintendent pharmacist (SP), delivered the service with the support of the team. The pharmacy was busy. But the team had organised the vaccination service so that it did not adversely affect the pharmacy's day-to-day activities. So, though the SP was busy, he managed to administer vaccinations while also managing his usual responsibilities. And he engaged with the inspectors and answered their questions.

The GPhC had received a concern about a website (https://www.chemist4now.co.uk) which this pharmacy was linked to. This inspection visit had been prompted by this concern and was undertaken to gather information about the nature and extent of the pharmacy's relationship with the website. The SP explained that he knew the owner of the Chemist4Now website and his company Pharmaexpo. And he knew that the owner was also the SP of Pharmaexpo's pharmacy, My London Pharmacy. The SP had been approached by the owner to dispense prescriptions from the online prescribing service. And so the SP began dispensing prescriptions issued through the website in August 2022. He explained that he had dispensed around 35 prescriptions from Chemist4Now. And that the figure was relatively low compared to the number of prescriptions received from other routes such as NHS and other private prescriptions. The pharmacy's total prescription numbers were approximately 10,500 per month.

The SP had not completed any risk assessments for the Chemist4Now service. And he had not completed any audits for prescriptions received by it and dispensed for it. Nor did he have any standard operating procedures (SOPs) in place for dispensing chemist4Now prescriptions. And he didn't have access to any prescribing policy or protocols used by Chemist4Now prescribers. When asked what due diligence checks he had completed, the SP explained that as the prescribers were registered with UK regulators, he felt this was sufficient. The inspectors and the SP discussed the importance of having robust governance in place for all pharmacy services. This included governance for the prescribing services his pharmacy was associated with. One of the inspectors showed him the GPhC guidance for registered pharmacies proving pharmacy services at a distance, including on the internet with specific reference to the following statement: 'make sure that your website and the websites of companies you work with are arranged so that a person cannot choose a POM before there has been an appropriate consultation with a prescriber. It should be made clear that the decisions about treatment are for both the prescriber and the person to consider together during the consultation'. After these discussions the SP stated that he would cease activity with Chemist4Now. The inspectors clarified that they were not asking the SP to stop the service. But highlighted to the SP that all pharmacy services, including those in association with a third party, must meet GPhC standards and adhere to GPhC guidance.

While the pharmacy did not have a SOP for dispensing prescriptions from Chemist4Now, the SP explained the procedure he followed. The pharmacy received the prescriptions on two different platforms. One platform had been developed by Chemist4Now and the other was a commercial offering from a third party. But the SP had only used the third-party platform and did not use the platform designed and hosted by Chemist4Now. The SP described how he also used the Royal Mail Click and Drop service. This consisted of a list of prescription orders generated by prescribers. And each pharmacy which used the service could see details of all the prescription orders created by all prescribers using the service. The SP explained that Newport Pharmacy only accessed orders for which they received a prescription. But the prescription orders on the Royal Mail platform contained details of the medicine and the patient including email addresses, postal addresses, names and telephone numbers. And so every pharmacy using the service could see who had a prescription order on it as well as the details of what they had been prescribed. After receiving the prescription the SP compared the prescription against the order and dispensed the medicines prescribed. These were then collected by Royal Mail and shipped from the pharmacy via a Royal Mail courier. The pharmacy could track the delivery of the dispensed medicines through the Royal Mail system. But the tracking did not include a signature from the person it had been delivered to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The inspectors conducted the inspection during the pharmacy's usual trading hours and found the SP present as the regular RP. He was supported by five pharmacy team members comprising a dispensing assistant (DA), two trainee DAs, a medicines counter assistant (MCA) and a trainee MCA. One of the trainee DAs had worked at the pharmacy for just two weeks and so had not yet been registered on a recognised training course. The pharmacy had a small team whose members worked regularly together. And overall, they were seen to work effectively with one another. The daily workload of prescriptions was in hand and people were generally attended to promptly for both the vaccination service and the pharmacy's other regular services. The SP was seen to support team members when they needed his advice and assistance. The SP could make day-to-day professional decisions in the interest of patients.

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

Summary findings

The pharmacy is linked to a website which allows people to choose a prescription-only medicine before beginning a consultation with a prescriber. And so it it does not comply with General Pharmaceutical Council (GPhC) guidance. But the pharmacy's premises provide a suitable environment for people to receive its usual services. They are tidy and organised and sufficiently clean and secure. The pharmacy provides an adequate environment to deliver it services from. And it keeps them secure.

Inspector's evidence

Contrary to GPhC guidance, people using the prescribing service website could select a prescription only medicine (POM) before a consultation had taken place or before completing a questionnaire. And the website didn't make it clear that decisions about treatment were for both the prescriber and the person to jointly consider during the consultation, but the final decision would be the prescriber's. In addition, each POM had prices attached and had a link alongside it to 'Request Treatment'. The page displaying the POMs also had a pop up which displayed a promotion for '5% off all treatments'. This could promote the inappropriate sale of POMs to people using the website. The website did not state the names or registration numbers of the prescribers working for the service or the name of the owner or Superintendent Pharmacist. The website used a questionnaire model to gather information relating to the person requesting treatment(s). The questionnaires for POMs were designed in such a way that the user could alter their responses. And so they could then proceed through to purchase the POM. An example of this was seen for the consultation questionnaire for Ozempic injection for weight loss.

The pharmacy's physical layout included a customer area and medicines counter with the dispensary behind. And a further large dispensing room to the rear. The walkway linking the counter area to the dispensary and rear dispensing room extended across an access area and side door for people living in the flats above. But the pharmacy secured the doors into both parts of its premises at night to prevent unauthorised access. The walkway between the counter and dispensary was large enough to accommodate a chair and a small desk. And this was where people received their flu vaccinations. The team followed a cleaning routine to ensure that contact surfaces were clean. And so, the pharmacy was generally clean and tidy. The dispensary had a single run of dispensing bench in the main dispensary and a separate run of dispensing bench in the larger dispensing room to the rear, which was used for managing repeat prescriptions. And dispensing and checking multi-compartment compliance packs.

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

Summary findings

The pharmacy's procedures for ensuring that medicines prescribed through an online prescribing service are supplied appropriately are inadequate.

Inspector's evidence

The pharmacy's entrance provided step-free access. Its customer area was free of clutter and unnecessary obstacles. And it had a delivery service for people who found it difficult to visit the pharmacy. It could also order people's repeat prescriptions if required. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. The pharmacy also supplied medicines against private prescriptions, several of which had recently come from the online prescribing service for a limited range of conditions. The prescribing service used both medical and nurse independent prescribers.

Following the inspection the SP provided one of the inspectors with examples of a range of private prescriptions generated by prescribers working for Chemist4Now. And against which medicines were supplied by Newport Pharmacy. Some prescriptions were electronically generated, and they contained a statement which made the authority to supply unclear. The statement said the medicine was:

...prescribed by Dr Colin Galloway GMC no. 4102786, OR Authorised under PGD by Tania Al-Hassani GPhC 2064706 or Yousef Yaghoubi GPhC 2218268...'

But it did not clarify which. In addition a further statement at the bottom of the prescription indicated that the quantity supplied be:

'determined by the dispensing pharmacist'.

This made it difficult to ascertain the authority of the prescription and intentions of the prescriber or person authorising the supply. Electronic prescriptions appeared to have an electronic signature attached. The signature appeared to be in the form of a two-factor authentication code which had been generated for each prescriber. Although this was not defined in any risk assessment or SOP. Several electronic prescriptions also contained a copy of people's consultation questionnaires. But the SP did not have access to any patient notes showing the prescriber's decision-making process. The pharmacy also received a number of hand-written paper prescriptions from Chemist4now. Prescribers emailed a copy of the prescription to the pharmacy and then forwarded the original in the post. But the pharmacy had not conducted a risk assessment for receiving prescriptions by email and supplying the medicines before the prescription had been received.

Stock on its shelves was tidy and organised. And a random sample of stock checked by one of the inspectors was in date. Short-dated stock was identified and highlighted. And the team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities for providing its services safely. And it keeps them clean.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was generally clean. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment, in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had several computer terminals which had been placed in the main dispensary and rear dispensing room. Computers were password protected and team members had their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.