General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chemist.net, Lexon site, 18 Oxleasow Road, East Moons Moat, REDDITCH, Worcestershire, B98 0RE

Pharmacy reference: 1100545

Type of pharmacy: Internet / distance selling

Date of inspection: 02/07/2024

Pharmacy context

This is a pharmacy which is closed to the public and provides its services at a distance. The pharmacy is on an industrial estate on the outskirts of Redditch and in the same building as a large wholesaler. The pharmacy dispenses NHS and private prescriptions. And it sells medicines online. This includes 'pharmacy only' (P) medicines, 'general sales list' (GSL) medicines and veterinary medicines. The pharmacy does not offer any enhanced or advanced NHS services. The pharmacy has two online websites https://www.chemist.net/ and https://www.vetpharmacy.co.uk/.

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

The pharmacy largely has the right processes to identify and manage risks associated with its services. Members of the pharmacy team deal with their mistakes responsibly. But they are not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. The pharmacy keeps the records it needs to by law. And team members understand their role in protecting the welfare of vulnerable people. But they could do more to consider any similar risks to animals.

Inspector's evidence

The pharmacy had an appropriate range of documented standard operating procedures (SOPs) in place to provide guidance to the team about the services it provided. They were specific to the nature of the pharmacy's business. Staff had read and signed them. Team members were clear about their roles. The correct notice to identify the pharmacist responsible for the pharmacy's activities was also on display.

The pharmacy had procedures in place to identify and manage risks associated with its services. In line with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet', relevant risk assessments and audits had been completed to verify the safety and quality of the service being provided. There was, therefore, effective oversight in place to oversee the safe supply of medicines. People could contact the pharmacy and raise complaints through their main website (chemist.net). The pharmacy's complaints procedure was outlined here. Documented policies were also in place to manage incidents. The RP and manager confirmed that there had been no incidents since the last inspection.

The workflow in the dispensary involved staff preparing prescriptions in one area and the responsible pharmacist (RP) checking for accuracy from another section. This helped minimise distractions and errors. Staff used paper bags to hold prescriptions and medicines during the dispensing process which helped prevent any inadvertent transfer between them. Once the dispensing labels had been generated, details were marked on them to help identify who had been involved in the dispensing processes. This was routinely used as an audit trail. The dispensary was very organised and clear of clutter. As the pharmacy was closed to the public, there were fewer distractions, and a lower likelihood of mistakes occurring because the team could concentrate more easily. Staff recorded mistakes which occurred during the dispensing process (near misses). Only a few were seen to be documented every year, this was said to be due to the way the pharmacy operated, the volume of workload, because staff processed prescriptions one at a time and their using bags to hold prescription(s) and item(s) when they were dispensed. There was also minimal stock held in the dispensary which helped reduce mistakes because stock was ordered and matched to prescriptions when it arrived. However, the near misses were reviewed informally with no details recorded to help verify any trends or patterns seen or action taken in response.

The pharmacy had suitable processes in place to protect people's confidential information. Unauthorised staff could not access the dispensary, computer systems were password protected, sensitive information was stored suitably, and confidential waste was shredded. Staff were also trained on data protection and used their own NHS smart cards to access electronic prescriptions if required. The pharmacy obtained people's consent to dispense and supply medicines against NHS prescriptions

through their website. This included consent to nominate the pharmacy to receive electronic prescriptions. The pharmacy had documented policies in place to underpin safeguarding vulnerable people and people's confidentiality.

The pharmacy's team members had been trained to safeguard vulnerable people. The responsible pharmacist (RP) had been trained to level three for this. However, there were no documented details seen about safeguarding animals or agencies that staff could refer to the event of a concern. In addition, at the point of inspection, there were no checks being made to ensure that the person purchasing medicines were who they claimed to be. Staff were reliant on people telling the truth (about their age) when they entered relevant information at the consultation stage. This risked potentially supplying medicines inappropriately. Following the inspection, evidence was received confirming that the company had approved and were implementing as priority, an identity verification and authentication service through LexisNexis.

The pharmacy's records were compliant with statutory and best practice requirements. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. The RP record and records of supplies made against private prescriptions were completed appropriately. Records to verify that the temperature of the fridge had remained within the required range, had also been maintained. The pharmacy had suitable professional indemnity insurance arrangements in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to suitably manage its workload and provides its services using a team with various levels of experience. But some team members are not completing essential training in a timely manner. Whilst they have access to suitable reference sources, staff have not completed, nor are they undertaking any specific training about animal medicines. This could mean that they don't know enough about the medicine(s) they are supplying for animals to provide suitable advice.

Inspector's evidence

Staff at the inspection included the regular RP and the manager who was enrolled onto relevant accredited training for the NVQ2 in dispensing. There was also a member of staff classed as a 'picker/packer' for online orders and a member of staff described as processing orders who dealt with admin. The latter was also enrolled onto accredited training to complete the NVQ2 in dispensing. Out of the team, the manager and RP were the two most predominantly involved in dispensing prescriptions. The manager was a long-standing member of staff. She was observed to be competent in her role and understood the needs of the business well. However, she had not completed this essential training since the last inspection. This was due to dealing with the day-to-day running of the pharmacy and the inspector was told that there was no protected time to complete essential training. In addition, the RP routinely used the NOAH compendium to check orders. He had not completed any specific training to enhance his knowledge of animal medicines. This situation increases risks. Staff were up to date with the workload. As they were a small team, they communicated verbally and regularly discussed things with one another. The pharmacy had changed ownership in the recent past and weekly meetings with the company's digital team were said to be taking place. Staff would also have access to the company's suite of training resources to keep ongoing training up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for the delivery of healthcare services. The premises are secure and kept clean. And the pharmacy has sufficient space in line with its workload to deliver its services safely.

Inspector's evidence

The pharmacy premises were located inside a warehouse unit. The dispensary consisted of a small room which had an adequate amount of space in accordance with the pharmacy's volume of work. Orders were processed upstairs from a shared admin area although the pharmacy team were based together in one section of this area. There were only PCs and workstations here. The pharmacy was clean, clear of clutter, presented professionally and secured appropriately. Unauthorised access was restricted, and people could not access the pharmacy without team members being present. The pharmacy did not have a consultation room, this was not required given the nature of the services the pharmacy provided.

The pharmacy's websites were used to access services. This consisted of the pharmacy's own online website (https://www.chemist.net/) which listed some veterinary medicines but a wider range of veterinary medicines could also be obtained through https://www.vetpharmacy.co.uk/. People could not add medicines to their basket before undertaking a consultation and the system used by the pharmacy prevented people from changing their answers if their purchase was rejected.

The vetpharmacy.co.uk website was registered with the veterinary medicines directive (VMD) accredited internet retailer scheme; the link for this and relevant details were displayed at the bottom of the website. Both websites also displayed the GPhC's voluntary internet pharmacy logo. This provided reassurance to the public that this was a registered pharmacy and neither website had direct reference to any prescription-only medicines (POMs). Details of the regular pharmacist, the pharmacy's registered address, email details and telephone number could be located under the 'contact us' section for the first website along with a few details of the owner of the company. However, at the point of inspection, both websites had not updated details of the change of ownership fully. There was initially incorrect information listed about the superintendent pharmacist (who was the superintendent of the previous owner) and details of previous pharmacists who were no longer associated with the pharmacy. This was therefore, not fully in line with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet'. This was rectified following the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers medicines to people suitably. The pharmacy's team members store and manage medicines well. And they can show that they sell over-the-counter medicines to people online, in a safe way. But they don't always record any relevant information about interventions when they supply medicines against prescriptions or ask appropriate questions for people receiving higher-risk medicines. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied. The pharmacy may also need to reconsider the questions it uses when it sells medicines for animals so that they are in accordance with necessary requirements.

Inspector's evidence

The pharmacy's workload consisted of four different workstreams. The pharmacy team supplied medicines against NHS prescriptions which were received electronically and private prescriptions (for humans as well as animals) which were received through the post. Some private prescriptions were received direct from veterinary clinics. For prescriptions written by veterinary practitioners for the treatment of animals, medicines were supplied under the 'cascade' guidance. In addition, the pharmacy sold, and supplied P and GSL medicines as well as veterinary medicines through the websites described in Principle 3.

For people who regularly received their medicines against NHS prescriptions, the RP described telephoning to counsel, or advise of, for example, dose changes. However, this information was not documented on people's medication records (PMR) to help verify. There were also no routine checks being made for people prescribed higher-risk medicines or medicines that required ongoing monitoring. The team did not ask relevant questions or details about their treatment nor was this information regularly recorded. The pharmacy had not supplied sodium valproate.

Although people could place orders for private prescriptions through the pharmacy's website, staff waited for and did not prepare medicines until the private prescription arrived in the post. After receiving private prescriptions, the team made necessary checks to ensure that the prescribers were registered with the appropriate regulator. Each prescription was also screened to confirm details such as changes and to ensure it was legally compliant before medicines were dispensed. However, interventions made by the pharmacist had also not been documented.

For sales of medicines online, the RP processed orders from the admin section upstairs. This involved screening the answers that people had given in the online consultation. Only the RP could approve or reject sales. If people required counselling, advice would be given by email or by telephone. Counselling notes for medicines purchased were seen to be documented. This included refusals. The RP explained that most refusals were usually for veterinary medicines where people had attempted to purchase a medicine which was licensed for another animal. They were directed accordingly. Staff had access to the 'NOAH compendium' as a reference source. Repeat prescriptions and sales of veterinary medicines were seen, they were usually for horse wormers. In response to the most recent clinical audit undertaken by the pharmacy, promethazine containing medicines were no longer sold online. People could only purchase one pack of any P medicine within 28 days. The RP could add people along with their respective details to a 'bar list' which identified and prevented them from abusing the system or attempting to obtain more medicines in 28 days or more than what would normally be required.

Medicines available to purchase on the pharmacy's veterinary website included medicines that were classed as POM-V and POM-VPS. For the former, these products require a prescription from a vet and can be supplied by a registered pharmacist or veterinarian. The requirements for this class of veterinary medicine were clearly highlighted on the website. POM-VPS products can be supplied by a registered qualified person (RQP [i.e., a pharmacist, vet, or suitably qualified person (SQP)]. People were required to complete a consultation before medicines could be purchased. The questions for POM-VPS checked if the person purchasing was the owner or keeper of the animal, if the animals being treated had been signed out of the food chain, if the animal had been treated with alternative medication previously or with the product in question, what the product would be used for, how old the animal was, whether the animal was taking any other medication, if they were pregnant, the weight of the animal, how many animals would be treated and the type of animal being treated (cat, dog, horse, other was listed).

However, on randomly selecting some POM- VPS products and NFA-VPS, the consultation questions were all the same. So, they were potentially not tailored to the products, and this could be confusing for people purchasing these medicines. The questions asked did not consider whether the animal was in good health and whether the customer had been provided with the warnings on the SPC (summary of product characteristics). In addition, the pharmacy used a disclaimer at the end of every consultation to confirm that the customer was aware of any contra-indications, that they would read any product specific warnings and that they had checked the latest SPC on the VDM's product information database. If they were unaware of how to use the product in question, then they take full responsibility to seek advice from an appropriately qualified person. This delegated and put the onus back on the customer to have read and understood relevant details about the medicine. This may not have been in line with the VMDs expectations who clearly state that the requirements on the RQP are non-delegable and cannot be transferred to the customer. These points were referred to the VMD to enforce or provide guidance as required.

Once these processes were complete, medicines were delivered to people in the UK by Royal Mail or DX Courier. This service could be tracked. Medicines that required refrigeration were delivered with ice packs. The latter had been quality assured through Lexon to ensure medicines were kept cool and the cold chain maintained during the delivery process. Medicines were dispatched in robust blank packaging. For failed deliveries, two to three attempts were made, and the team contacted the person. The medicine(s) were then returned to the pharmacy and destroyed, with a refund issued. If people wanted to return medicines to be destroyed, they could post them back to the pharmacy.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy held limited stock, and this was stored in an organised way. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were identified. Fridge temperatures were checked daily. CDs were stored securely. Drug alerts were received electronically via email. Staff explained the action the pharmacy took in response and relevant records were kept verifying this

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate range of equipment and facilities it needs to provide its services safely. Its team members keep the equipment clean and use it in a way which helps keep people's confidential information safe.

Inspector's evidence

The pharmacy's equipment was clean. It included a dispensary sink to reconstitute medicines, standardised conical measures, an appropriately operating pharmacy fridge, a legally compliant CD cabinet, access to appropriate reference sources and triangle tablet counters. Computer terminals were password protected and confidential waste was shredded. Containers to dispose of waste medicines including hazardous ones were readily available. Staff had access to a canteen as well as WCs in the shared facilities.

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.