General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Evercaring Pharmacy, Unit 4 Acorn House, Longshot Industrial Estate, Longshot Lane, BRACKNELL, Berkshire, RG12 1RL

Pharmacy reference: 1116378

Type of pharmacy: Internet / distance selling

Date of inspection: 29/01/2020

Pharmacy context

This is a distance selling pharmacy located in a small unit on an industrial estate in Bracknell. It changed ownership in 2017. It has an NHS distance selling contract and it supplies a very small number of repeat prescriptions each month. Its main business is selling over- the-counter (OTC) medicines online via its websites, www.dailychemist.com and www.evercaring.uk. People do not visit the pharmacy in person and all medicines are delivered by Royal Mail.

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 have clear written procedures to support online supplies of medicines. It has not completed any risk assessments to provide assurance that its services are safe. And it cannot show that it has fully considered the risks in relation to the supply of high-risk medicines.
		1.2	Standard not met	The pharmacy has not audited or reviewed its services to make sure they are being provided safely.
		1.6	Standard not met	The pharmacist does not have full access to records of people's purchasing history when making supplies. And the pharmacy does not keep clear records showing why requests for medicines are approved or refused. So the pharmacy cannot clearly demonstrate that all supplies are appropriate.
		1.8	Standard not met	The pharmacy does not have a documented safeguarding policy to make sure vulnerable people are protected. And it sells medicines that are known to be abused, when other safer alternatives may be more appropriate.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is untidy and disorganised. Its websites contain misleading or inaccurate information and the MHRA EU logo is not displayed on one of the websites. Sales are incentivised through overinflated pricing discounts. And the website allows people to purchase more than one pack of codeine containing medicines, which is not appropriate.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Medicines are not always stored in an orderly manner or managed effectively. Medicines sent by post are not always appropriately packaged. This mean people may not get all the information they need to use the medicines safely. And there is a risk the medicines could be damaged.

Principle	Principle finding	Exception standard reference	Notable practice	Why
		4.4	Standard not met	Appropriate action is not taken in response to medicine safety alerts, and the pharmacy's website lists medicines that have been recalled.
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 effectively manage all of the risk associated with its services. Working procedures sometimes lack transparency and services are not proactively reviewed or audited to make sure they are safe. The pharmacy sells some over the counter high-risk medicines liable to abuse when safer alternatives are available. And whilst some basic safeguards are in place to mitigate this, these are not sufficiently robust to ensure all sales are appropriate.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) that had been reviewed and signed by the current superintendent in March 2019, when she took on the role. These procedures covered dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CD). Regular locums and the pharmacy owner had also signed the SOPs. But written procedures did not specifically cover online supplies which were the main work of the pharmacy, so SOPs did not fully reflect current practice and meant that working procedures lacked transparency. The superintendent explained how she conducted online sales of medicines in the pharmacy, but she had limited knowledge of how the websites or customer service element operated as this was done at another location.

There were near miss and incident reporting processes but no incidents had been recently documented. Only 20-30 NHS prescription items were dispensed each month which explained the low level of reporting. The superintendent said no dispensing errors had been reported since she started working. Usually the pharmacist dispensed and checked all medication herself, but she was not working under time pressure so was able to take a mental break between assembly and accuracy checks.

The pharmacy's contact details and complaints procedures were outlined on the pharmacy's websites. Complaints were dealt with by the pharmacy owner in the first instance and referred to the superintendent if her input was needed. Occasional complaints about broken or damaged bottles of OTC medicines being delivered had been reported. These were only replaced or refunded if photographic evidence was provided. Bottles were now being packaged in boxes rather than bags so they were better protected. The pharmacy did not have a complaints log providing an over view of any concerns or complaints received, so common issues might not necessarily be identified and addressed.

The pharmacy had professional indemnity insurance with the NPA, and a current certificate was displayed in the pharmacy. A responsible pharmacist (RP) notice was displayed and an RP log was maintained. Prescription supplies were recorded on a recognised web-based patient medication record system. The superintendent said they did not have a current private prescription record as private prescriptions were not being supplied. No schedule 2 CDs had been supplied since she started working. A CD register was kept but it could not be located at the time of the inspection. She subsequently confirmed this had been found the following day. No unlicensed medicines were supplied and therefore specials records were not required.

People had to register with the websites in order to buy medicines. Orders were processed by the customer service team remotely, and WWHAM questions were sent by email. Postage labels with order details were generated by the customer service team and emailed to the pharmacy to be printed out. The answers to WWHAM questions were reviewed by the superintendent who authorised all sales. She

did not have access to their account or full ordering history. She was required to spot multiple requests or potentially duplicate accounts, by crossmatching previous delivery label details. She could also ask further questions or contact people by email or telephone if needed. Payment for orders was only processed once they were marked as 'completed' by the pharmacist.

The pharmacy was registered with the Information Commissioners Office; details were provided by the superintendent. She confirmed the websites and emails were encrypted, and they used secure and encrypted VPN connections and designated laptops for remote working. Privacy policies were displayed on the websites. Confidential material was suitably stored. Confidential paper waste was shredded. Medicines were posted in opaque packaging, so the contents were not visible. Individual pharmacist smartcards were used to access patient data in relation to NHS prescriptions. The superintendent did not have Summary Care Record access but had applied for this.

The superintendent had completed the Centre for Pharmacy Postgraduate Education safeguarding training. The pharmacist was aware that some of the medicines listed on the pharmacy's website were liable to abuse but there was no written policy associated with this. The pharmacist refused sales on a regular basis if she suspected misuse or if requests were too frequent. The superintendent could not provide specific data relating to the supplies made by the pharmacy. When asked about the type and number of sales, she said an average of 70 orders were dispatched each day. Around 40% of these were for high-risk medicines such as codeine containing medicines. She subsequently confirmed that on average 3-10 order each day were for codeine linctus. The superintendent estimated that three or four order a day were for Phenergan or promethazine containing products. Data provided after the inspection confirmed 690 bottles of codeine linctus and 59 Phenergan or promethazine containing products had been supplied in the last three months. On occasion, codeine linctus and Phenergan had been requested at the same time and the pharmacist said these were only very occasionally supplied together. These two medicines in combination are known to be abused. People requesting medicines containing codeine were asked to provide ID such as a copy of a driving license or passport. The superintendent indicated that she refused about half of the requests for codeine linctus that she received based on their WWHAM responses or because they had made a purchase within the last four months. When sales were refused, she sent templated emails advising people to contact their doctor or suggesting alternative medicines. Refused sales were then refunded. People's full purchasing history could not be viewed at the time of supply to support professional judgements. There was no evidence of risk assessments, or audits or reviews of sales to support the continued supply of high-risk medicines, despite the high levels of sales and refusals.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small close-knit team. There are enough team members to manage the workload and they communicate on a day-to-day basis. But relevant information is not easily accessible to everyone in the team, so the pharmacy does not have a completely clear and open culture.

Inspector's evidence

The only person working in the pharmacy at the time of the inspection was the superintendent pharmacist and she often worked alone. The pharmacy owner, who was a qualified dispenser, visited occasionally to provided support when they were busy, but otherwise worked remotely and effectively acted as the customer service team. They were in daily contact and used email and a spreadsheet on a shared drive to manage the workload and communicate. The only other team member that the superintendent was aware of was an IT specialist who managed the websites.

Regular locums covered the pharmacist's days off and holidays and could be called to cover sickness. The pharmacist felt the workload was generally manageable, but it could be busy at the start of the week as orders were often placed over the weekend.

The pharmacist could easily contact the owner and raise issues. She had raised concerns about the system enabling multiple pack orders and felt this was being addressed. But her knowledge of some aspects of the business was limited for example, she could not provide detailed information about the pharmacy's ancillary sites or the customer service operation.

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

Summary findings

The premises are secure and spacious enough for the pharmacy's service. But general organisation is lacking, and the pharmacy's websites contain some inaccurate or misleading information. And one website does not display its mandatory EU logo needed to sell medicines online.

Inspector's evidence

The pharmacy was situated in a small unit on an industrial estate. Other businesses operated from the same address with a shared access point, car park and toilet facilities.

It was an older unit and so the décor and fittings were worn in appearance. The pharmacy consisted of two rooms; one was used as the dispensary and the other housed the website computer servers. Fittings were basic and it was windowless, so poorly ventilated. A portable air conditioning unit could be used to control the room temperature if needed. An extractor fan in the server room that usually stayed continuously on, and there was a ventilation vent over the main door entrance for cross ventilation.There was around four metres of work bench, a sink, a desk, some chairs and shelving. It was cluttered and untidy in places and the sink needed cleaning.

The company was registered with the MHRA to sell prescription only medicines (POMs), general sales list (GSL) medicines and pharmacy (P) medicines. The www.dailychemist.com website bore the EU logo however the link to the MHRA website was not working on the day of the inspection. The following day the superintendent confirmed that it had been fixed. The website listed a range of GSL and P medicines. It also listed some POMs, but the superintendent said these were not currently being supplied although they were developing a prescribing service. The website contained the company and superintendent's details but also included some other inaccurate information about the team. This information was removed from the website the following day although it did still list POMs and indicate an online doctor service was available which could be misleading. And sales of medicines via the website were potentially incentivised by misleading or artificially discounted pricing of medicines. For example, codeine Linctus Sugar Free 200ml Syrup was discounted from an overinflated price of £19.99 to £9.79.

The www.evercaring.uk website primarily promoted the pharmacy's NHS prescription service. Medicines did not appear to be listed although when a product was typed into the search function of the website, a small range of GSL and P medicines were seen to be listed, these included codeine linctus and hay fever products. The superintendent said occasional orders were initiated via this site. The website did not display the EU logo which is required by law.

Both websites allowed people to purchase more than one pack of a codeine containing medicine. The superintendent said she never sold more than one pack at a time and people were only charged for what was supplied.

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

Summary findings

The pharmacy manages its services, so people receive their medicines on time. It obtains its medicines from licensed wholesalers, but stock medicines are poorly organised, and medicines are not always managed or handled safely. And appropriate action is not taken in response to medicine safety alerts.

Inspector's evidence

The pharmacy operated Monday to Friday 9am to 5pm. Orders were usually dispatched by Royal Mail within 48 hours. People could request different delivery options and were issued with a tracking number. Only prescription deliveries required a signature to confirm delivery. When OTC tablets or capsules were supplied, these were removed from the carton so they could be packed flat. The carton and leaflet were included, but this method meant people were likely to lose or discard the medicine carton with instructions about how to take their medicines safely. Five or six boxes containing bottles of codeine linctus had been pre-prepared in anticipation of orders. Bottles were wrapped in bubble wrap and placed in boxes. Dispensing labels were faint which could make it difficult for people to read and they did not include details of the pharmacy address.

Medicines which were returned as undelivered are not returned to the pharmacy. The return address on the postage label was in Feltham. The superintendent was not aware of this address and she did not know of any medicines that had been returned undelivered. She subsequently confirmed this was a mistake and had been rectified so undelivered items were now being returned to the pharmacy.

Only persons living in the UK over the age of 18 were allowed to purchase medicines. Date of births were requested as part of the registration process, but were only confirmed for those requesting codeine containing medicines who were asked to email some proof of ID. People could contact the pharmacy by email or telephone. The customer service team managed email correspondence in the first instance. Telephone calls came directly through to the pharmacy during working hours but could be picked up by the customer service team out of hours.

Stock medicines were obtained from licensed wholesalers. The pharmacy was FMD compliant and so was decommissioning POMs when making prescriptions supplies. The shelves containing stock medicines were frequently untidy with offcuts and loose strips not in their original packaging. The pharmacy had a waste contract with designated provider. The pharmacy had small amount of POM and CD stock, and much of this was obsolete or nearly expired as it had been previously used when the pharmacy supplied care homes. Expired medicines had been removed from the shelves, but these had been left in boxes on the floor, rather than placed in the designated pharmaceutical waste bin and might be mistaken for active stock. Fridge lines were not currently being supplied but the pharmacist said she still monitored the fridge temperature. The fridge contained several expired medicines. There was a small key coded CD safe which contained a small amount of stock. The pharmacy did not routinely accept patient retuned prescription medicines and usually signposted people to their local pharmacy.

The pharmacist said drug and device alerts were usually received by email and she checked these on a daily basis. But she was unable to provide any evidence that recent alerts had been received and actioned. Several GSL ranitidine products (Zantac / Ranicalm / Noumed) were found amongst stock. Some of these had been recalled in the autumn 2019, but they were still listed on www.dailychemist.co

m. The superintendent said she felt sure they had not supplied any since the alert had been issued.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services. It suitably stores and maintains the equipment, and it has the facilities to secure people's information.

Inspector's evidence

The pharmacy had a single computer terminal and it was password protected. The websites, payment details and pharmacy emails were encrypted. Opaque packaging and bags were available for posting medicines. The team had access to the BNF and NPA information services. Most items were supplied as original packs, but tablet cartons were available. The pharmacy had a sink, CD cabinet and medical fridge.

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.