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: Community

Date of inspection: 02/11/2020

Pharmacy context

This is a distance selling pharmacy. It is situated in a small unit on an industrial estate in Bracknell. People do not visit the pharmacy in person and all medicines are delivered by Royal Mail. The pharmacy has an NHS distance selling contract, but it only dispenses a very small number of NHS prescriptions each month. Its main business is selling over- the-counter (OTC) medicines online via its websites www.dailychemist.com and www.evercaring.uk. It also has an online prescribing service offering a range of lifestyle prescription medicines as well as asthma inhalers. The prescriber is registered to practice in Spain, but he is not registered with the General Medical Council. The inspection was undertaken during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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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	There are insufficient safeguards in place to make sure that online supplies of OTC medicines are appropriate, particularly in relation to the supply of codeine linctus and medicines containing promethazine, such as Phenergan Elixir, which are liable to misuse and abuse.
		1.1	Standard not met	There are insufficient safeguards in place to make sure that all online supplies of prescription medicines are appropriate. The procedures in relation to the prescribing service are not always followed. This means risks are not effectively identified and some supplies of medicines might not be appropriate.
		1.2	Standard not met	The pharmacy does not effectively audit the safety of its prescribing services.
		1.6	Standard not met	The pharmacy does not keep private prescription records as required by law. Clinical record keeping is insufficient as it does not contain enough information to justify prescribing decisions.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy team members lack experience and they have limited access to additional professional support. Customer services team members are not trained for the role they undertake and they are not supervised by a pharmacist.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's www.dailychemist.com website allows people to select a prescription only medicine (POM) before the consultation with a prescriber. The website does not contain sufficient information about the prescriber,including their qualifications and their location, to enable patients to make an informed choice. Both of pharmacy's websites use unprofessional terminology and contain some misleading information.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy operates a transactional approach when supplying medicines, which does not effectively prevent people obtaining medicines that are not suitable or could cause

Principle	Principle finding	Exception standard reference	Notable practice	Why
				them harm. It supplies large amounts of codeine linctus and medicines containing promethazine, such as Phenergan Elixir which are liable to abuse.
		4.2	Standard not met	The pharmacy does not always obtain enough information to make sure supplies of prescription medicines are safe and appropriate. The pharmacy's prescriber sometimes operates outside the scope of the service. And the pharmacy does not proactively share relevant information with other health professionals involved in the care of the person or make sure that appropriate monitoring is in place, when supplying prescription medicines such as asthma inhalers. This means people's use of medicines may not be appropriately controlled and their ongoing condition might not be properly monitored.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy lacks a whole system approach to risk management. There are insufficient safeguards in place to make sure that online supplies of medicines are appropriate. This means that there are some risks to patient safety, particularly in relation to supplies of codeine linctus and medicines containing promethazine, such as Phenergan Elixir, which are liable to misuse and abuse. The pharmacy does not effectively audit the safety of its prescribing service or monitor compliance with working procedures. Record keeping is inadequate as the pharmacy does not keep records of private prescription supplies as required by law. And clinical records are limited as they do not include enough information to clearly justify prescribing decisions.

Inspector's evidence

The majority of the pharmacy's workload involved supplying OTC and prescription only medicines (POMs) via its associated websites www.dailychemist.com and www.evercaring.uk. The pharmacy only supplied people over the age of 18. Most supplies were made to people living in the UK although occasional supplies of erectile dysfunction drugs were made to people living elsewhere in the EU. NHS activity was minimal; the pharmacy managed repeat prescription medication for around ten long standing patients which equated to less than 100 items each month.

When ordering medicine via the websites, people were required to create an account using an email address, so there was a purchase history associated with each account. Consultations consisted of online questionnaires for both OTC medicines and POMs. Orders were initially processed by the customer service team (CST). The pharmacy owner confirmed an Address Verification System (AVS) was used to check if the billing address matched the address of a credit card holder, and supplies were only delivered to this address. The system also automatically flagged up different accounts reusing the same credit cards and IP addresses. Additional identity checks were only completed for people requesting codeine linctus who were required to upload photographic evidence in the form of a driving license or passport when ordering. The pharmacy did not complete any additional checks to verify people's identity when purchasing POMs, so they may not always notice if people use more than one account to obtain medicines, or use someone else's details. This was particulalry relevant when supplying treatments for chronic conditions such as asthma, as it could mean their use of medication might not be properly controlled.

Requests for POMs were reviewed by the prescriber and an electronic prescription was issued. Once processed and approved, OTC orders and prescriptions were visible to the pharmacy team on the pharmacy's IT system so they could review, assemble and dispatch them. The pharmacy team, the CST and the prescriber were located in different countries. They rarely communicated directly with the pharmacy and the RP did not fully understand their roles and responsibilities or how they operated. The responsible pharmacist (RP) usually communicated with the prescriber via the pharmacy owner. The pharmacy was heavily reliant on the pharmacy owner to manage the business operations and coordinate the team members in different locations.

The pharmacy had written standard operating procedures (SOPs) which had been prepared by the pharmacy owner and agreed by the superintendent pharmacist (SI). Procedures covered dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CDs). The inspection focused on the SOPs for sales of medicines. Paper copies available in the pharmacy did not match some of the versions

available online. The RP had implemented some of her own systems as she was concerned about some of the orders they received when she started working at the pharmacy. Prescribing policies, associated SOPs and documents were provided after the inspection by the pharmacy owner. SOPs did not always reflect current practice and there was no evidence of audits being completed to ensure procedures were followed consistently.

The pharmacy supplied a wide range of OTC medicines, including treatments for allergies and hayfever, cough and colds, headaches and pain relief, and stomach and bowels. Medicines supplied included general sales list (GSLs) items and Pharmacy (P) medicines including high-risk items such as pain killers containing codeine, codeine linctus and promethazine products such as Phenergan liquid and tablets, which are all known to be liable to abuse and misuse.

The RP stated that she personally would not authorise repeat supplies of codeine linctus to the same person within six months, although the SOPs indicated these could be permitted after four months. She completed some additional manual checks that were not mentioned in the SOPs and had noticed some people using the same photo ID for more than one account in order to circumvent the system and obtain additional supplies. She had logged these on a spreadsheet which she had personally created. The RP also kept her own spreadsheet with approximate weekly totals of supplies and refusals made during August and September; the number of refusals averaged over 40 each week. During the same period; she estimated an average of 70-80 bottles of codeine linctus were supplied each week. She had not managed to keep this record up to date as it was time consuming to collate the data. The RP did not permit codeine linctus to be purchased at the same time as promethazine (Phenergan) as she knew these could be abused in combination. When she started working at the pharmacy, she had noticed that people sometimes requested codeine and Phenergan at the same time, and she was aware that the pharmacy had supplied these items together in the past as this was not prohibited in the SOPs. She estimated they had supplied around 30 Phenergan orders in October. In addition, she estimated they supplied approximately 20 orders of codeine containing painkillers each day.

The previous inspection had raised concerns about supplies of high-risk medicines including codeine linctus and Phenergan, bearing in mind people requesting these might be abusing them and may be also purchasing them elsewhere. The pharmacy owner explained that they had increased the retail prices in order to discourage people from buying these items, but the demand for them had increased. Safer alternatives were not routinely recommended, and interactive counselling was not provided. Other actions raised during the previous inspection hadn't been properly addressed. For example, there were no detailed records available explaining why supplies of high-risk medicines had been approved or refused.

The online prescribing service was relatively new having been initiated around six months previously. The prescriber was registered to practice in Spain rather than the UK, so the prescribing service was not registered with a UK regulator. The RP estimated around 40 electronic prescriptions were received each day. The prescriptions were apparently authorised with an advanced electronic signature, however this was not verified. Ventolin inhalers were one of the most frequently prescribed items. Other commonly supplied POMs included treatments for erectile dysfunction and acid reflux(omeprazole). The prescriber also regularly issued prescriptions for 100 paracetamol tablets.

The pharmacy had completed an overarching 'private prescription risk assessment' which identified some of the potential issues that might arise when providing an online prescribing service. But the pharmacy did not have individual risk assessments for each of the POMs they supplied, identifying issues specific to that medicine. The inspection focused on the prescribing of Ventolin inhalers as this was one of the most commonly prescribed item. The SOP for 'Dispensing Asthma Relievers' confirmed that the maximum number of inhalers the pharmacy would supply was three every 114 days, which was

in keeping with NICE guidance. The SOP explained the process which involved the prescriber accessing a person's Summary Care Records (SCRs) to check that supplies were appropriate, but this did not happen in practice. Access to SCR was not mentioned during the inspection, but when contacted afterwards, the RP confirmed it was her who accessed these records using her NHS Smartcard, and she would only do this when people requested repeat supplies too frequently. This meant that the pharmacy did not always seek to verify a diagnosis of asthma for each person it supplied.

The pharmacy's contact details, and complaints procedures were outlined on the pharmacy's websites. Complaints were dealt with by the pharmacy owner and the CST. There was a basic incident reporting log which combined both dispensing and dispatch related near misses and errors. Incidents noted included packaging and quantity errors. The RP confirmed she discussed these with the trainee dispenser to make sure they didn't happen again.

The pharmacy had professional indemnity insurance with the National Pharmacy Association. A RP notice was displayed and a log was maintained. No schedule 2 or 3 CDs had been supplied since the RP started working at the pharmacy. CD registers were not inspected. NHS prescription supplies were recorded on a standard patient medication record system (PMR). All online supplies of medicines were recorded on the company's IT system linked to the websites. Private prescription records could not be viewed at the time of the inspection. The RP did not know if it was possible to extract this data from the system and a separate record was not kept. Clinical records in relation to the prescribing service were limited to questionnaire responses and brief 'order notes'. These did not clearly show how prescribing decisions were made or include details of communications with the pharmacy's prescriber or the patient's GP.

The pharmacy was registered with the Information Commissioners Office. The pharmacy owner confirmed that they were compliant with the General Data Protection Regulation. Both websites and emails were encrypted, and the team used secure VPN connections for remote working. Privacy policies were displayed on the websites. The RP believed people provided consent to access their SCR and contact their GP as part of the prescribing service terms and conditions, but this was not demonstrated. Confidential material was suitably stored. Confidential paper waste was shredded. Medicines were posted in opaque packaging, so the contents were not visible.

The RP had completed level two safeguarding training. She was aware that some of the medicines the pharmacy supplied could be abused and explained that she had sometimes emailed to refer people requesting medicines inappropriately to their GP or other sources of help, but records supporting this were not provided.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team lacks experience and they have limited access to additional professional support, because the superintendent is currently not working. Customer services team members have not received any accredited pharmacy training and they are not supervised by the pharmacist, but they are directly involved in the sales of medicines. This means there is a lack of professional oversight which means people may be more likely to get medicines that are not suitable for them. The team members work from several locations, some of which are overseas, and there is a lack of collaborative working. This means the team dynamic is dysfunctional and team members may not get the opportunity to share important information, ideas and knowledge.

Inspector's evidence

The RP was a provisionally registered pharmacist. She started working at the pharmacy at the end of July after finishing her pre-registration placement in a traditional community pharmacy. She confirmed this type of pharmacy model was new to her and she had no previous experience of providing online pharmacy services. The RP confirmed a workplace risk assessment had been completed when she started working, and that her senior pharmacist providing supervision was the SI who was currently on maternity leave and living in Greece. The SI was contactable, and the RP was in regular contact with the pharmacy owner, who was the sole director of the company and a qualified dispenser. She worked remotely but visited the pharmacy regularly. The SI had previously worked as the regular RP until July 2020.

The RP sometimes worked alone but she was supported by a part-time trainee dispenser during the inspection. The dispenser had started working at the pharmacy in the last two or three months and she confirmed she was enrolled on a Buttercups course. The RP was unsure where the CST was located or what training these team members had completed. The pharmacy owner later confirmed customer services had been outsourced and they had four team members; two working in the Philippines managing telephone calls, and two in India managing email correspondence. She had personally recruited them and had provided them with training and instructions. But they had not completed any formal accredited pharmacy training, and they did not work under the RP's supervision. The prescriber, Dr Rodolfo Castro (General Practitioner, OMC Registration Number: 0836482), was currently based in the USA but registered to practice in Spain. The prescriber's identification details and qualification certificates were provided by the pharmacy owner. Direct communication between the different locations and team members was limited. There were no regular whole team meetings or equivalent methods to promote an open discussion and enable sharing of information and knowledge.

Approximately 100 orders were processed by the pharmacy team each day and most of these were generated via dailychemist.com. Orders were usually dispatched the same day and the RP felt they had enough staff to manage the workload. The RP worked five days a week and had not taken any leave since starting work. The pharmacist felt able to raise concerns; she had previously informed the pharmacy owner that she was not happy to supply codeine linctus and Phenergan products together and she said she had not objected to this. The pharmacy team members were not set targets or incentivised to make supplies.

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

Summary findings

The pharmacy premises are basic in design and function and are reasonably secure. The pharmacy is fairly small and so cluttered in places, which impacts negatively on the working environment. The www.dailychemist.com website layout enables a person to choose a prescription medicines before filling in the consultation questions. This is not appropriate as it means people may not always receive the most suitable treatment for their needs. And the identity and the location of the prescribing service is not made clear on the website. Both of pharmacy's websites use unprofessional terminology and contain some misleading information.

Inspector's evidence

The pharmacy was situated in a multi-occupancy business premises on an industrial estate. The pharmacy occupied a small unit on the ground floor. It consisted of a main dispensary and a small side room which was used for storage. There was a single entrance from the main corridor. A couple of internal doors led to adjacent units, but these were permanently sealed. The pharmacy was windowless, so there was no natural ventilation. A portable air conditioning unit was used to control the room temperature. The pharmacy was fitted with around three metres of work bench, open shelving, two desks and couple of chairs. Décor and fittings were worn in appearance and the pharmacy was cluttered and untidy in places; some stock was left on the floor and multiple wires were suspended loosely from the ceiling.

The company was registered with the MHRA to sell prescription only medicines (POMs), general sales list (GSL) medicines and pharmacy (P) medicines online. Both the www.dailychemist.com and www.evercaring.uk websites bore the MHRA EU logo. They did not have the GPhC voluntary internet logo, so the pharmacy's registration with the GPhC was less easy to verify.

The dailychemist.com website listed a range POMs under conditions such as 'asthma' or 'erectile dysfunction'. The website did not always clearly indicate if medicines were prescription only medicines (POMS) and it was arranged so that a person could choose a POM before filling in the consultation questions. Unprofessional terminology such as 'add to cart' and 'checkout' were used to invite consumers to purchase POMs and promote sales. The website also listed OTC and P medicines for a range of conditions. Medications included various high-risk medicines such as codeine containing painkillers, codeine linctus, Collis Browne and antihistamines including Phenergan products.

The dailychemist.com website contained the company and superintendent's details, and the prescriber's details and OMC number. The OMC (Organización Médica Colegial de España) regulates the Spanish medical profession but this was not explained on the website and the location of the prescribing service was not made clear. A pharmacist prescriber (Roshaniben Patel GPhC registration number: 2079399) was also listed on the website although they were not actively prescribing.

The evercaring.uk website primarily promoted the pharmacy's NHS prescription service. OTC medicines did not appear to be promoted on the website although when a product was typed into the search function of the website, a small range of GSL and P medicines were listed; these included codeine linctus and hay fever products. A couple of erectile dysfunction drugs were listed under the 'online doctor' function and the same pharmacist prescriber was listed on this website as the sole prescriber, a lthough no POMs were being supplied via this website.

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

Summary findings

The pharmacy generally sources and stores its medicines appropriately. It supplies significant amounts of medicines to people via its websites. This includes OTC medicines which are liable to misuse, such as codeine linctus and Phenergan Elixir, and prescription medicines, including a large number of asthma inhalers. The pharmacy operates a transactional approach when supplying these medicines, which does not effectively prevent people obtaining medicines that are not suitable or could cause them harm. Interactive consultations and counselling are not provided. And the pharmacy does not proactively share relevant information with other health professionals involved in the care of the person or make sure that appropriate monitoring is in place, when supplying prescription medicines. This means people's use of medicines may not be appropriately controlled and their ongoing condition might not be properly monitored.

Inspector's evidence

People accessed the pharmacy's services via the associated websites. The pharmacy operated Monday to Friday 9am until 5pm. People contacted the pharmacy via the customer service team rather than contacting the pharmacy directly. All medicine supplies were dispatched by Royal Mail and these were tracked. People could request different Royal Mail delivery options. Medications were suitably packaged, and bottles were wrapped in bubble wrap to make sure they were protected. Approximately ten bottles of codeine linctus and some paracetamol had been pre-packed in anticipation of orders that day. Dispensing labels for prescriptions medicines were faint which could make it difficult for people to read. Medicines which were returned as undelivered were logged and the customer service team was notified.

People wanting to purchase medicines completed questionnaires before the sale was approved. These contained leading questions with simple' yes/no' or suggested answers, for example the codeine linctus questions included: 'are you going to treat a dry, tickly and annoying cough with this medicine?' P medicines questionnaires were initially reviewed by the CST; red flag answers could be seen by the pharmacist for Dailychemist.com orders, but not for Evercaring.uk. So, the RP did not have full access to these questionnaires to inform a professional judgement decision when making supplies. Similarly, anyone wishing to obtain a prescription medicine also needed to complete a questionnaire. The questionnaire to request salbutamol inhalers contained closed questions or questions with suggested answers. This meant the questionnaires could be easily navigated to make sure a supply was obtained. The IT system captured information which indicated if people had altered their answers on the questionnaires, but the RP did not have sight of this information, and it was unclear how effectively this information was utilised.

The RP explained that when orders for codeine linctus were refused, this was usually because people failed to provide photo ID, rather than as a result of a professional intervention triggered by answers on the questionnaire. The RP reviewed codeine linctus orders to confirm ID had been provided and checked whether other high-risk medicines had been ordered at the same time. If people requested more than one high-risk OTC medicine, additional questions would be sent by email and usually only one of the selected items would be supplied. The pharmacist did not speak to customers purchasing medicines and she hadn't really considered that people may also be purchasing them elsewhere, or how they could mitigate this risk. It was difficult for people to speak to a pharmacist as all contact with

the pharmacy was directed via the customer service team and telephone call wait times were long. A follow up call made after the inspection predicted a wait time of up to an hour.

The RP had access to POM questionnaires and reviewed these as part of the clinical check once a prescription was received. The RP did not normally contact the prescriber direclty but raised prescription interventions via the pharmacy owner. One prescription was noted where sildenafil was prescribed for a female patient and had been sent to the pharmacy for dispatch. The RP explained that she would usually seek confirmation from the prescriber about this as it was off-license use, but she thought they had sometimes made similar supplies. Several supplies for people with female names had been supplied Viagra were noted in the prescription data provided. This was outside the scope of the pharmacy service, as the questionnaire was based on the use of sildenafil for the treatment of erectile dysfunction and would not provide sufficient information to justify prescribing. Furthermore, off-license use for sildenafil requires specialist monitoring which the pharmacy did not offer. Up to three Ventolin inhalers could be supplied at once. The RP had noticed that people sometimes re-ordered inhalers too frequently, so she had started to refuse additional supplies within three months. She was aware that asthma required ongoing monitoring as a chronic condition. The prescriber did not routinely access the patient's SCR to inform the clinical decision making or check when their last asthma review had been completed or a prescription for inhalers was issued. This meant the prescriber did not always have access to all the necessary information at the point of prescribing and was reliant on the RP's input. The RP stated that she usually only accessed SCR to check this information when she noticed frequent requests. And the pharmacy did not routinely notify the person's GP when a supply of inhalers was made.

Stock medicines were obtained from licensed wholesalers. The shelves containing stock medicines were reasonably tidy. A few items that were not in the original packaging were kept in cartons with batch number and expiry dates. A date checking system was in place; no expired stock was found on the pharmacy shelves. The pharmacy had approximately 60 bottles of codeine linctus and 45 bottles of Phenergan linctus in stock. Further boxes of Phenergan 25mg tablets were found on the shelves. The RP explained that the pharmacy owner tended to order frequently used items like codeine-based medicines, Phenergan and Ventolin. Invoices for September found several invoices for codeine linctus and Phenergan, including 140 bottles of Phenergan linctus and 100 boxes of Phenergan tablets. An invoice from October for 200 codeine linctus was noted although the RP could not recollect this being delivered. The pharmacy had large stocks of other commonly used item; the side stock room contained more than a dozen outer boxes of Ventolin inhalers.

The pharmacy had a pharmaceutical waste contract and waste medicines were segregated in a designated waste bin. Fridge lines were rarely supplied and only a couple of packs of Duac were found in the fridge. The fridge temperature was in range and maximum and minimum temperatures were monitored. There was a small amount of schedule 2 and 3 CDs stock, most of which was expired and had been segregated. The pharmacist confirmed that drug and device alerts were usually received by email and she checked these regularly. Recent alerts had been received and actioned.

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. IT systems were password protected. The websites, payment details and pharmacy emails were encrypted. Opaque plain tamper proof packaging and bags were available for posting medicines. Bubble wrap was used to protect glass bottles. The team had access to the BNF and the internet for research. Most items were supplied as original packs, but tablet cartons were available. Staff had face masks, hand sanitiser and cleaning equipment. The pharmacy had a small CD cabinet and a medical fridge for the storage of medicines.

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.