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: 14/06/2022

Pharmacy context

This is a distance selling pharmacy situated on an industrial estate in Bracknell. People cannot visit in person, and the pharmacy delivers its medicines via Royal Mail. The pharmacy has an NHS distance selling contract, but it only supplies a very small number of NHS prescriptions. Its main activity is online retailing via its website www.dailychemist.com. People can buy over- the- counter medicines and the pharmacy has an online prescribing service. This means people can request prescriptions medicines used to treat a range of conditions including erectile dysfunction and asthma. The pharmacy's prescribers work as doctors in Spain and the prescribing service is not monitored by a UK healthcare regulator. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 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 not all met	4.2	Standard not met	The pharmacy sells medicines via its website. But it does not always provide enough information for people to be able to make sure the medicines they choose are safe and appropriate for them. And people can request combinations of medicines which are not safe to be taken together. In addition, people using the pharmacy's services cannot easily contact the pharmacist for information and advice.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally manages the risks associated with its services and it keeps the records it needs to by law. The pharmacy team members understand their roles and responsibilities, and the pharmacy keeps people's information safe.

Inspector's evidence

The pharmacy was owned by Dr Rani Ltd. It was the only pharmacy owned by the company. The sole director of the company managed the business. She was not a pharmacist. A regular pharmacist worked at the pharmacy Monday to Friday as the responsible pharmacist (RP) supervising the supply operation. The superintendent (SI) visited the pharmacy occasionally, but he did not work there on a daily basis.

The pharmacy had two websites www.dailychemist.com and www.evercaring.uk. Most of its workload involved supplying over-the-counter (OTC) and prescription only medicines (POMs) to people using the dailychemist.com website. The evecaring.uk website contained information about the pharmacy and it listed a few OTC medicines. The pharmacist confirmed that people did not usually purchase medicines from this website. The pharmacy mostly supplied people living in the UK although it sometimes supplied medicines to people living in Europe. Occasional supplies to people living in the USA had recently stopped on the instructions of the director. The pharmacy worked with two doctors who were registered to practice in Spain. As the doctors were based overseas, the prescribing service was not monitored and inspected by a UK healthcare regulator.

The pharmacy processed a large number of orders each day. The pharmacist estimated that around 70% of orders were for prescription medicines. All prescriptions were authorised by the two doctors based in Spain. The most prescribed items included treatments for erectile dysfunction (ED), asthma inhalers and proton pump inhibitors. NHS activity was minimal; the pharmacy dispensed less than 50 items each month.

People ordering medicines via the websites had to create an account using an email address, so there was a purchase history associated with each email account. People had to complete a consultation before they could obtain a medicine, which consisted of online questionnaires for both Pharmacy (P) medicines and POMs. Orders were initially processed by the customer service team (CST) who completed ID checks and payments for before sending the order to the pharmacy. ID checks involved using an address verification system to check if the billing address matched the address of a credit card holder. The system also automatically flagged up different accounts reusing the same credit cards and IP addresses. The pharmacy did not complete any additional ID checks such as requesting photo ID even though the pharmacy's risk assessment stated this would be requested for people living in Europe. This meant there was a possibility that people could use someone else's details to obtain medicines.

The prescribers reviewed requests for POMs and if approved, they issued an electronic prescription. The prescriptions were apparently authorised with an advanced electronic signature that was unique to the doctor authorising the supply. The pharmacist viewed the orders including copies of the prescriptions on the IT system. She clinically checked prescriptions and approved all medicine requests before generating dispensing and dispatch labels which the team used to assemble and dispatch the

orders.

The pharmacy had up to date standard operating procedures (SOPs) which generally explained how it operated. The director had prepared most of the SOPs, and they had been agreed by the SI who had taken on the role in June 2021. A matrix in the SOPs identified team members' individual roles and responsibilities. Team members could access the SOPs via the intranet using their personal log-in and the system identified when they had read them. The SOPs for the prescribing service also attributed clinical input to two GMC registered doctors, and they made reference to and included links to national prescribing guidelines for the UK. SOPs generally reflected the pharmacy's working practices but the level of detail was sometimes lacking. For example, the SOP for OTC medicines did not specify some of the quantity restrictions for high-risk items such as laxatives or Orlos, which is used for weight loss.

The pharmacy supplied a wide range of OTC medicines, including treatments for allergies and hayfever, cough and colds, pain relief, and stomach and bowels. Medicines supplied included general sales list (GSLs) items and P medicines including high-risk items such as pain killers containing codeine, which are known to be liable to be overused and misused.

The pharmacist checked all prescription supplies before they were dispatched. Dispensing labels included an audit trail to show team members involved in the assembly process. The team discussed any errors, so they could learn from them. The pharmacy had a risk assessment highlighting potential issues with the business model and risk assessments relating to the online prescribing service which identified some of the risks to specific individual medicines that might arise.

The pharmacy's websites contained contact details and the complaints procedures. Complaints were initially dealt with by the CST and the director was the complaints manager. The pharmacist was not routinely involved in resolving complaints and she was not aware of the number of complaints the pharmacy received. The GPhC had received more than 20 customer service-related complaints about the pharmacy over the last two years including several in the last two months. The concerns were all around the same themes as people complained that they had not received their medicine as expected. Some people described how they could not make contact with the pharmacy to find out what the issue was and that their complaint was not effectively resolved. The pharmacy also regularly received a number of negative online reviews. The pharmacy had completed an audit looking at a number of negative online reviews and one of the most recent complaints. Based on estimated figures, the audit suggested that most people had a positive experience when using the pharmacy's services with only 0.2% providing negative feedback. It identified that most of the negative feedback was because people experienced delays receiving a refund when the medicine they requested was not supplied. This resulted in the pharmacy developing an action plan to improve monitoring of online reviews, implement a stock checking system to prevent orders proceeding when stock was not available, training the CST to call rather than email people who were experiencing difficulties, and trialling a ticketing system for managing customer queries. The effectiveness of these actions could not be determined as the plan had not been fully implemented.

The pharmacy had professional indemnity insurance. The RP displayed a notice with their details, and the pharmacy maintained an RP log. The historic RP logs were not available as the pharmacy had recently changed the recording system, but the pharmacist believed the director had access to them. CD registers were available. The pharmacy had not supplied any schedule 2 CDs since the pharmacist started working there nearly two years previously. A standard patient medication record system (PMR) recorded NHS prescription supplies. All online supplies of medicines were recorded on the pharmacy's bespoke IT system and private prescription records were integral to this system. Clinical records in relation to the prescribing service were limited to questionnaire responses and brief notes attributed to the prescriber.

The pharmacy was registered with the Information Commissioners Office. The pharmacy team members understood their responsibilities in terms of data protection and confidentiality. The pharmacist logged in to the IT system using a secure VPN connection, so emails were secure. Privacy policies were displayed on the websites. People provided their GP's contact details anf their consent for the pharmacy to access their NHS Summary Care Record (SCR) and their GP's contact details when requesting treatments for asthma. The pharmacist used her own smartcard to access SCR. Confidential material was stored securely and paper waste was shredded.

The pharmacy only supplied people over the age of 18. The pharmacist was the only pharmacy team member who ever had contact with people using the services. She had completed level two safeguarding training. If she had concerns about a person overusing medication, she refused to supply and contacted them to signpost them to their GP. The CST team also had contact with people using the services and training records provided by the director indicated they had completed some safeguarding training; however, their level of understanding could not be confirmed as they did not work at the pharmacy premises.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members involved in supplying medicines receive the right training for their roles. But the structure of the business with staff working in different locations means that the pharmacist may not always fully understand how other team members carry out their roles or whether they have the right skills and competence. And whilst the pharmacy team members can provide feedback, this is not always acted on, so the pharmacy may miss opportunities to make improvements to its services.

Inspector's evidence

The pharmacy team consisted of the RP and a full-time trainee dispenser. A new starter was working part time completing a trial period pending longer term employment. Non-pharmacy team members included the two doctors and at least five customer service operatives. The CST included team members based in India and The Philippines, so English was not their first language. The CST did not work directly under the supervision of the pharmacist and the director was responsible for managing them. The pharmacist could contact the superintendent for advice if needed but other team members could not. The director was in regular contact, and the pharmacy team members could call her if needed.

The pharmacist was recently qualified, and this was her first role following registration. As the pharmacy was supplying a lot of salbutamol inhalers, she had completed some continuing professional development studies relating to asthma. The dispenser was completing a recognised course. The new starter had previous experience of working in a pharmacy, but she did not have a recognised qualification. The pharmacist confirmed she would enrol her on a course if she was permanently employed. The CST had not completed any formal pharmacy training, but the director provided records to show they had received training on the relevant SOPs. The director also provided copies of the prescribers' ID and qualification certificates. The pharmacist had not met or spoken to the prescribers herself and she was unsure of their background or in what capacity they were working in Spain.

As the pharmacy team, the CST and the prescribers were in different locations, they communicated by email and a messaging system linked to the pharmacy's IT system. The pharmacist was reliant on gaining assurances from the director about the external systems and procedures which were not under her control. For example, the doctors' level of input and the ID checking systems. The pharmacist did not appear to know everyone who worked in the business as she did not know the team member who signed the emails which were sent by the pharmacy to people's GP, or in what capacity the person was working.

The pharmacist, director and the CST had recently attended a conference call to discuss the recent audit and they were intending on having these meetings regularly moving forward. The pharmacist was not set any targets and she felt able to exercise her professional judgement and could refuse to supply orders. Whistleblowing guidance was available on the intranet. The pharmacist communicated with the director on a daily basis. She described how she provided feedback and made suggestions, but these were not always acted on. For example, issues with the website listings when discontinued medicines were not removed from the website, or an issue which she'd identified which meant people could add two different salbutamol inhalers to their basket when the pharmacy would only supply one type. This meant orders had to be refused and refunded when this could be easily avoided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are basic but suitable for the services it provides. Its websites do not always contain the most accurate and up to date information, so people may not be able to make a fully informed choice when deciding to use the pharmacy's services.

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 two adjoining rooms; a dispensary and a side room used for storage. There was a single entrance from a corridor shared with other businesses. There were a couple of internal doors which led to adjacent units, but these were permanently sealed. The pharmacy was windowless, so there was no natural ventilation. Portable heaters and a fan could be used to control the room temperature, but it was not monitored to ensure the environment was suitable for the storage of medicines. The pharmacy team has access to shared toilet facilities in the same building.

The pharmacy was fitted with work bench, open shelving, and a desk. Décor and fittings were basic and sometimes worn in appearance. The pharmacy was reasonably well organised, but it was cluttered in places with boxes on the floor due to the lack of storage space.

The pharmacy's websites included details about the pharmacy so people could check the registration with the GPhC. But they did not include a live link so people could not check this easily. The websites contained the company, superintendent, and the responsible pharmacists' details. However, the Evercaring.uk website displayed the responsible pharmacist's provisional registration number and the MHRA EU logo which were both obsolete. The dailychemist.com website included the prescribers' names, their registration numbers, and website addresses for the Spanish authorities to check their registrations. But it was not easy to check their registration as the website addresses did not directly link to the websites and the websites were mainly written in Spanish, so not easy for most people living in the UK to navigate. And there was no information on the website about the pharmacy's indemnity arrangements. The dailychemist.com website incorrectly stated the pharmacy was regulated by MHRA on the 'about us' page. And the website did not make clear that parts of the pharmacy services were provided at different locations so people who used the pharmacy could understand where each part of the service was based.

The dailychemist.com website listed a range of POMs under conditions such as 'asthma' or 'erectile dysfunction'. The website listing showed which medicines were available for each condition and the prices. The website directed people to start the online consultation for the condition they wished to treat before being able to select a medicine.. The website sometimes used inappropriate transactional language such as 'add to cart' which gave the impression people were purchasing medicines rather than accessing a healthcare service.

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

Summary findings

The pharmacy promotes medicines for purchase on its website. Whilst the pharmacy has continued to make improvements to its working practices, it does not always provide enough information about the medicines it sells or explain how to use them safely. This means people may not make the most suitable choice when selecting medicines. And people cannot easily contact a pharmacist for information and advice. The pharmacy obtains medicines from recognised suppliers, and it generally stores, manages, and delivers them safely.

Inspector's evidence

The pharmacy operated Monday to Friday 9am to 5pm but people could place an order at any time. The website listed POMs, OTC and P medicines for a number of conditions. Some website listings for P medicines did not include any information about the medicine. For example, the listings for Veganin and co-codamol tablets and kaolin and morphine mixture. And other listings contained only limited information about the medicine often without any safety advice. This means people may purchase medicines without fully understanding what they are used to treat

The websites included a contact telephone number and email address, but these were both directed to the CST. The pharmacist was reliant on the CST forwarding her any pharmacy related queries as people could not contact the pharmacy team directly, and the telephone meni to not give an option to speak to the pharmacist. If people asked specifically to speak to the pharmacist, the CST gave a number which directed to the pharmacist's personal mobile, but this rarely happened possibly because people assumed they were already speaking to the pharmacy team. Feedback from service users seen in complaints suggested it was difficult to get through to the pharmacy and that there were communication issues. And the CST were not pharmacy trained, so they might not understand which queries were more appropriate to refer to the pharmacist. This meant people could not easily seek advice about their medicines or speak to the pharmacist.

The pharmacist demonstrated how she reviewed and approved orders on the IT system before printing the dispatch and dispensing labels. The pharmacy team, prescribers and CST communicated via the electronic messaging system which was integral to the main IT system. Each team member's actions and communications relating to each supply could be seen on the system so there was an audit trail. The pharmacist was able to view the online questionnaire responses, the person's order history and information which confirmed ID checks were complete. For the prescribing service, she could also view the electronic prescription and brief 'notes' attributed to the prescriber. These appeared to be pre-formatted wording simply stating they were following UK guidelines and could see no reason not to supply based on the information provided. There was no evidence of further communications between the prescriber and the person requesting the medicine and the pharmacist felt this rarely happened.

The pharmacist could authorise or decline orders or ask for more information from the person requesting the medicine by email and these communications were captured on the system. Supplies were rarely refused on the basis of questionnaire responses and people could easily navigate these in order to obtain the medicines they wanted, so prescribers tended to approve most requests and issue prescriptions providing the ID checks were passed. It was essentially the responsibility of the pharmacist to make additional checks and refuse supplies. The pharmacist could add notes and had to

confirm all stages of the clinical check were completed on the system when authorising a supply.

The pharmacist completed additional checks for people requesting asthma inhalers. She checked the person's SCR to confirm a diagnosis of asthma and that they had had an asthma review within the last year before authorising a supply. The pharmacist also usually checked whether they were using a preventor inhaler. If she could not verify this information, the order was placed 'on hold' and the pharmacist requested further information from the person concerned. The pharmacist estimated more than 20 orders a day were not progressed in this way. People often did not respond to the pharmacist's email or provided invalid responses and so the pharmacist rejected these orders. The pharmacist sometimes contacted the person's GP surgery directly if they could not find an SCR record to confirm if the person was registered and to check their details. The pharmacy supplied up to three inhalers at a time and would only supply a maximum of three inhalers in three months to the same person. An email was automatically generated by the system and sent to the person's GP when the pharmacy supplied inhalers. This explained the pharmacy had supplied the person with a salbutamol inhaler, but it did not include the quantity of inhalers, so the GP might not be aware if the person received more than one inhaler. The pharmacy did not provide any additional information when it supplied inhalers such as advice on inhaler technique.

The maximum quantity for ED treatments of 64 tablets per month and this could be issued on a single prescription. ED treatments could also be requested on a subscription basis, so supplies could be repeated every month, two months or three months up to a maximum of six months when the person was required to confirm there were no changes to their health before further supplies would be made. There were incremental cost savings with the subscription service which could potentially encourage people to over order or overuse the medicines.

For proton pump inhibitors, up to 112 omeprazole and 84 lansoprazole could be supplied at a time. The pharmacist usually refused further requests within the same year and signposted the person to their GP, but this restriction was not stated in the SOPs. The system automatically sent an email to the person's GP when proton pump inhibitors were supplied but again the quantity was not included. And it was not compulsory for the person to provide their GP's details, so this did not always happen. Other items less commonly supplied included Duac for acne and treatments for herpes.

The pharmacy's system retained cookies for seven day and in some cases considerably longer so completed questionnaires were retained on the system. This meant could add items to their 'cart' without updating the questionnaire. This could mean the pharmacy may not have the most up to date health information when assessing requests for a prescription medicines. However, the pharmacist confirmed that she could see that date when the questionnaire was completed on the system and checked this when completing her clinical check. The website also allowed people to add more than one medicine used to treat the same conditions to their basket, such as different types of proton pump inhibitors, salbutamol inhalers or codeine containing painkillers. Whilst the pharmacist confirmed she would refuse to supply such orders; this could be misleading for people using the pharmacy's services

The pharmacy had recently updated its IT system and there were a few teething problems with the transfer of information. For example, the system had not captured all of the notes relating to a recently dispatched order when this was checked. The pharmacist could not search the new system using the person's details and could only search by order number. This meant she was not able to search for and view a person's records on the new system in event of query, for example if a GP contacted the pharmacy to ask about one of their patients. And it meant that historic records could not be viewed during the inspection to verify whether the pharmacy applied checks and recorded notes consistently. The owner subsequently confirmed that the pharmacist could access to the legacy

system if needed.

The pharmacist reviewed and approved all orders for P medicines. She could view the online questionnaire on the system, the ID check confirmation and the person's order history. People could make bulk purchases of medicines such as antihistamines The pharmacy only supplied one pack of a codeine containing medicine at a time and the pharmacist said she would not issue further to the same person within a 6-month period. She also imposed some restrictions OTC supplies of laxatives and pseudoephedrine to discourage overuse. The pharmacy's OTC order history was not accessible to the pharmacist as only orders processed that day were visible on the system, so it was difficult to determine the scale, nature and appropriateness of these supplies.

The pharmacy used Royal Mail's tracked postal service to deliver medicines ordered through the website. People could provide a different delivery address to their actual address when ordering their medicines and they could track their order via the website. Royal Mail collected the medicines for delivery from the pharmacy in the afternoon. The pharmacist could track deliveries and photographs were often provided as proof of delivery. The pharmacist completed a customs declaration when sending orders outside the UK. The pharmacy used discrete and protective packaging to prevent the contents being revealed. The pharmacy did not supply any cold chain medicines other than Duac which was kept in the fridge until the point of supply. The pharmacy did not use cold chain packaging, but the team assembled Duac orders just before the Royal Mail collection and the medicines were usually delivered the next day. The pharmacy had a process for dealing with orders returned as undelivered. It quarantined any undelivered medicines when it received them and the team did not re-use returned medicines.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept medicines in the original manufacturer's packaging. The shelves were reasonably tidy. The pharmacy didn't supply valproates. But the pharmacist knew that people in the at-risk group should not take valproate unless there was a pregnancy prevention programme in place. The pharmacy team had recently completed an expiry date check of the pharmacy stock. But it did not record when it had done these checks so it could not demonstrate how frequently the team completed these. The pharmacy team placed unwanted medicines in a pharmaceutical waste bin for collection by an authorised waste contractor. The pharmacy had a small CD cabinet and there were a small number of obsolete CDs awaiting destruction which the SI was arranging with the CD accountable officer. There was a fridge for storing medicines. The pharmacy did not have any fridge lines currently in stock, but the team monitored the temperature to make sure it was functioning properly and in range. The pharmacist explained the process for dealing with alerts and recalls about medicines and medical devices, and how she filed email alerts once she had checked them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities to provide its services safely. Equipment is appropriately maintained and used in a way which protects people's privacy.

Inspector's evidence

The pharmacy had a single computer terminal. IT systems were password protected. The websites, payment details and pharmacy emails were encrypted. Electrical equipment was in working order but there was no evidence on PAT testing. Opaque plain tamper proof bags were available for posting medicines. Bubble wrap was used to protect glass bottles. One item returned as undelivered was slightly damaged. But the pharmacist explained they normally packaged medicines in boxes which offered more protection, but they were waiting for these to be delivered. The pharmacist had access to the BNF and the internet for research.

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.