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: 22/05/2023

Pharmacy context

This is a distance selling pharmacy located on an industrial estate in Bracknell, England. The public cannot visit the premises. And medicines it supplies are sent via Royal Mail. It has an NHS distance selling contract, but this accounts for a small number of its prescription volume. Most of the pharmacy's activity is through its online service operated via dailychemist.com. This includes an online private prescribing service. And people can also buy a range of over-the-counter medicines and health products through the website. People can use the online prescribing service to obtain medicines to treat a range of conditions, including erectile dysfunction, asthma and weight loss. The pharmacy works with prescribers based in Spain. So the prescribing service is not monitored by a UK healthcare regulator. There are conditions in place preventing the pharmacy from selling codeine linctus and some medicines containing the drug promethazine.

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	1.6	Standard not met	The pharmacy uses unreliable record keeping systems which means records are not always accessible.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website which hosts the prescribing service, includes a medicine for weight loss which is not licenced for this indication. This is against regulatory guidance on the promotion of prescription only medicines outside the terms of their licence. And the website included reference to discounts which promoted specific prescription only medicines.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy relied on information provided by people in an online questionnaire when prescribing medicines for weight loss. And it did not verify the information provided, such as weight and height. This meant people would be able to obtain medicines that were unsuitable for them if they provided inaccurate information.
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 always keep the records that it is required to keep by law. The pharmacy uses an electronic system to keep its private prescription records but it is unreliable. So the pharmacy cannot always produce the records when they are needed or demonstrate that they are properly maintained. It generally identifies and manages the risks associated with its services. But it does not have appropriate safeguards in place to prevent vulnerable people from obtaining medicines by giving false information. The pharmacy team know their responsibilities and have procedures to support them in their roles.

Inspector's evidence

The responsible pharmacist (RP) record could not be located during the inspection visit. However, the pharmacy provided a copy following the inspection, and it appeared to be in order. The pharmacy used an online record system for their private prescriptions and consultation records. There were technical difficulties during the inspection visit which meant the records could not be accessed. A video conference was held a few days after the inspection, so that the records could be reviewed. But the Superintendent Pharmacist (SI) and RP were still unable to demonstrate live records. Samples of private prescription records were sent to inspectors. But these were in the form of photographs so could not be searched to identify repeat orders. The RP explained that they were able to view consultation notes written by the prescribers. And able to add notes if they needed to. Inspectors saw evidence of RP additions to people's consultation notes, for example, when the RP made checks relating to asthma treatment. Completed online questionnaires and other evidence relating to identity checks were also visible. Details of messages sent to people were also recorded. And there was an audit trail showing which members of the team had written notes and sent messages.

The pharmacy did not supply unlicenced medicines or make emergency supplies. Controlled Drug records were maintained appropriately. Running balances were recorded and regular balance checks were completed.

The pharmacy kept a log of near-miss incidents, where the wrong medicine had been selected during the dispensing process. The log included action to be taken to prevent a similar incident occurring in future. The pharmacy had a range of risk assessments in place which covered the online prescribing service and had recently been reviewed. They included risks associated with the individual medicines that were being offered by the service. There was also a risk assessment covering the sale of medicines that did not require a prescription, which included how the pharmacy confirmed the identity of people buying medicines and set maximum quantities that could be supplied. The risk assessments considered the level of risk for a range of hazards and included things the pharmacy had put in place to manage the risks. But the pharmacy did not sufficiently consider the risk of inaccurate information provided by people seeking medicines for weight loss. For example, the risk assessment for the online prescribing service identified the risk of people providing incorrect information to obtain medicines. But it did not consider how to verify information provided by people. Instead, it placed the responsibility onto the person seeking the medicine to provide truthful information.

There was a range of SOPs in place covering the pharmacy's services. These included how to dispense medicines and what to do if the RP was absent from the premises. A SOP was available which detailed the roles and responsibilities of the different members of the pharmacy team.

There were prescribing frameworks in place for asthma treatment and medicines used for weight loss, which included appropriate reference sources such as the British National Formulary (BNF) and national guidance. These outlined the consultation process used by prescribers. But there was no consideration of how prescribers verified the information provided by people seeking medicines for weight loss. So there was a risk that such medicines might be prescribed to people inappropriately.

The RP had completed audits of the pharmacy's dispensing processes and records in January and March of this year, which indicated that SOPs were being followed by the pharmacy team and records were maintained as they should be. The pharmacy had also completed audits of prescriptions for asthma treatments and weight loss medicines against the prescribing framework and SOPs. The audit on asthma treatment prescribing demonstrated how information people provided had been verified against their Summary Care Record (SCR). But the weight-loss audit did not demonstrate how the pharmacy verified the information people had provided.

The pharmacy provided evidence of indemnity insurance. Details of how to provide feedback was published on the pharmacy's websites (evercaring.uk and dailychemist.com). Complaints were managed by the pharmacy's customer service team with little involvement of the RP and SI. There had been several complaints relating to the weight loss prescribing service. These related to people paying for treatment for which a prescription was then declined by the prescriber. They then had to wait for a refund. As a result, the pharmacy had changed their payment system so that it did not take payment until a prescription had been issued.

The pharmacy used password protected computers and digital systems. And each member of the team, including the prescribers, had individual login details. There was an audit trail of who wrote in consultation notes. Confidential information was appropriately stored in a cabinet.

The pharmacy had a safeguarding SOP in place. And this was included as a control in their risk assessments. But the pharmacy did not have appropriate safeguards in place to prevent vulnerable people, such as those with eating disorders or body dysmorphia, from being prescribed medicines for weight loss.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the workload. Team members can provide feedback, but it is not always acted on. So the pharmacy could be missing out on opportunities to improve its service.

Inspector's evidence

There were two trainee dispensers working at the pharmacy along with the RP. The workload seemed manageable, and the team seemed to be up to date with general housekeeping tasks. However, there were technical problems with the pharmacy's computer system which the RP explained would result in delays in processing orders.

The pharmacy's online prescribing service used two regular medical prescribers who were based in Spain. Their registration was checked when they joined the prescribing service. And the RP regularly checked that registration was maintained.

The two trainee dispensers present at the pharmacy were working under the supervision of the RP. They had joined the pharmacy team a few weeks before the inspection and were due to be enrolled onto an appropriate training course to support their development in their new role. They were observed interacting with each other and seeking advice from the RP when they needed it. And there seemed to be a good rapport between the team.

The pharmacy used a customer service team who were based overseas. This team dealt with customer service queries, identity checks and managing notifications to people's primary prescriber, such as their GP. The customer service team did not receive dedicated pharmacy-based training or supervision from the pharmacy team. But they did receive in-house training to support them to complete their roles.

The SI did not work at the pharmacy premises but provided support remotely. The pharmacy was owned by a limited company, and one of the directors was the main point of contact if the RP had any problem or needed advice. There was limited contact between the pharmacy team and the overseas prescribers and there were no formalised operational or clinical team meetings held.

The RP explained that they felt confident to use their professional judgement and could refuse to supply any orders they did not think were appropriate. Examples were seen when asthma treatments were refused based on the additional checks completed by the RP. The pharmacy's computer system had a separate list of refused orders. They gave examples of suggestions they had made to the pharmacy's director to improve the pharmacy's operations. These included a request for an over-the-counter medicine to be removed from the website due to safety concerns and recommending that a system to monitor stock should be introduced. But these recommendations had not been implemented and there was no evidence that they had been considered.

The SI explained that the prescribers had no incentives to prescribe medicines and that prescribers used their professional judgement.

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

Summary findings

The pharmacy premises are generally well maintained and are suitable for the services provided. The pharmacy's website includes useful information for people using the pharmacy's services. But it identifies a medicine as a weight loss medicine which is not licensed for that purpose. And promoting off-label use of a Prescription Only Medicine (POM) is inappropriate. It also highlights a discount which is associated with prescription only medicines. So it could be viewed as promoting these medicines.

Inspector's evidence

The pharmacy operated two websites: evercaring.uk and dailychemist.com. The online prescribing service was accessible through the dailychemist.com website. The website was designed so that prescription only medicines (POMs) could not be selected until people completed a consultation with a prescriber. And key information about the prescribers and the SI was available. But the website identified a specific medicine as a weight-loss treatment when this use is outside the terms of its product licence (so-called "off label" use). There was a statement explaining that the treatment was off-label, but advertising or promotion of off-licence uses is not permitted. The same website included details of their "lowest price guarantee" which included a 10% discount on the next order if a lower price was identified from another supplier. This reference of a 10% discount was on pages where specific POMs were listed. So it could be interpreted by people using the website that the pharmacy was promoting the specific POMs listed.

The pharmacy had one entrance which was locked when not in use. People were not able to enter the pharmacy to use its services, they could only access them remotely. The pharmacy appeared appropriately clean. The pharmacy team had a cleaning schedule in place. And the RP had completed a recent audit which indicated that cleaning and waste control procedures were being followed. There was a logical flow to the workspace. And there was a separate area for the pharmacist to check items prepared for supply. But some stock medicines were being stored on the floor, which could pose a trip hazard to members of the team.

The pharmacy had hot and cold running water. And a fan was available for times of high temperature. And the pharmacy was secured from unauthorised access.

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

Summary findings

The pharmacy prescribes medicines for people based on the information they provide in online questionnaires. But it does not make sure that all of the information is true and accurate before it supplies medicines that are used for weight loss. This means people could obtain medicines that may not be safe or appropriate for them to use.

Inspector's evidence

The pharmacy premises was not open to the public. But people could access its services via the websites. And there was also the option for people to telephone or email the pharmacy. The RP was observed answering several calls during the inspection from people seeking advice. And there was a two-way messaging system which sent a link to people which could be used to provide advice and answer queries. Most of the orders processed by the pharmacy were for prescribing service items. Sales of over-the-counter medicines accounted for a relatively small proportion of the pharmacy's business.

People wanting to obtain treatments from the prescribing service were asked to complete a consultation. This involved them filling in an online questionnaire, which the prescriber then reviewed before deciding whether to issue a prescription for the requested treatment. The RP gave examples of checks they had completed when dispensing prescriptions issued by the prescribing service. One example was for salbutamol (a medicine used in the treatment of asthma). The RP checked the summary care records (SCR)for every person who was prescribed this medicine to ensure they had a diagnosis of asthma, that they had an asthma review within the past twelve months, that they were prescribed medicines to prevent asthma worsening and that they had been prescribed salbutamol previously. These were in place to prevent the inappropriate prescribing of salbutamol to people for who treatment may not be safe. If the RP identified any problems with their checks, the prescription was not dispensed and the person received a refund. The RP also demonstrated an example of a person being refused sildenafil (a medicine for erectile dysfunction) by a prescriber due to their history of having used it before without success. The person was referred to their GP for advice.

The pharmacy only checked people's SCR to verify information people provided when the medicines were being used for long term conditions, such as salbutamol. The SCR check was routinely recorded for salbutamol orders, but not for orders for weight loss medicines. And the pharmacist understood that the prescribers relied only on the information people provided in the questionnaires. This meant the pharmacy could not provide assurance that people requesting weight loss treatments had provided accurate information, or that the treatment would be suitable for them. The pharmacy had recently completed an audit of reasons for refusal to supply Ozempic for weight loss. But the orders had only been refused based on the information provided in the questionnaire. Which meant people could have provided false information to obtain medicines that would not be safe for them to use. Orders for weight loss medicines were restricted to one month's supply at a time. The system used by the pharmacy listed all previous orders, and this was checked by the RP before a repeat supply was made. And the pharmacy's risk assessment stated that the prescribing system highlighted when repeat orders for Ozempic were made. And that this triggered additional checks to be completed including monitoring of weight lost, side effects and that the dosage remained appropriate. But this could not be verified and the RP reported that no repeat orders had been placed because the weight-loss service had only been

operating for a number of weeks. People supplied with weight-loss injections were advised to take their used needles to a local pharmacy for safe disposal.

There was an audit trail in place which identified each team member involved with the prescribing and dispensing of medicines. Consultation records were available for the RP to view during their clinical check. And the RP was able to contact the prescribers if they had any queries relating to prescriptions they issued.

The pharmacy required people to consent to sharing information with their primary prescriber, such as their GP, when prescribing certain medicines. Examples included medicines which required ongoing monitoring such as salbutamol for asthma and Ozempic for weight loss. Examples of communications sent to GPs were available. These notifications were sent via email. The pharmacy rejected orders for people who did not or could not provide details of their primary prescriber. The pharmacy team was not responsible for sending these notifications. They were generated automatically by the IT system and managed by the customer service team. But the RP did not check if these had been sent. The RP stated that they had not received any feedback or queries from people's GP's in relation to these notifications.

A random sample of private prescriptions issued by the online prescribing service were inspected. Each prescriber had an individual advanced electronic signature. The prescription tokens did not include the date of prescribing. But the electronic prescription itself did and the date of prescribing could be identified by looking at the consultation notes and audit trail.

The pharmacy offered a range of medicines which could be bought without the need for a prescription. These included medicines for indigestion and migraines. The pharmacy had systems in place to detect multiple orders for these, and POMs, and identify people who attempted to obtain the medicines dishonestly. These included a mix of automated checks by the website based on address details and combinations of medicines. And manual checks of people's order histories by the RP. And there were maximum limits imposed on items available on the website to avoid inappropriate quantities being supplied.

The identify of people seeking medicines from the online prescribing service was checked using third party software. And the pharmacy maintained records of people who required additional checks to be completed based on their history of ordering.

People were normally sent any advice regarding their medicines by email. But there was also the option for people to call the pharmacy for advice or speak to the customer service team, who could then refer to the RP.

Medicines were sent to people using Royal Mail tracking. And each order was listed on the persons electronic record along with a tracking link. Medicines which required refrigeration were posted in insulated packaging. And any returned medicines which required cold storage were not re-dispensed. The pharmacy only processed orders for people resident in the UK.

A pharmacy fridge was used to store medicines that required cold storage. The team kept daily records of the maximum and minimum temperatures, which showed the fridge had remained within the correct temperature range.

Controlled drugs were securely stored. And the pharmacy had systems in place to check the expiry dates of medicines held as stock. But no records of date checking were kept so the pharmacy could not demonstrate when the checks had been completed. A random sample of stock medicines were checked, and no expired medicines were found. The RP explained that they also incorporated expiry

date checking into their final checks before packaging medicines for supply.

Alerts and notifications relating to medicines safety were reviewed by the RP and were sent to the pharmacy's email address. There was a SOP in place to outline the process of managing alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs for the services it provides. And the equipment is used in a way that protects people’s privacy. But its IT systems unreliable. So the team cannot always access records or provide services continuously.

Inspector's evidence

The pharmacy had one computer terminal which was used by the RP. And it was password protected. The pharmacy had telephones to speak to people seeking advice. The pharmacy's IT system was not operational during the inspection due to technical problems. And further technical difficulties prevented the SI from sending evidence to inspectors following the inspection.

The pharmacy used plain, tamperproof packaging to transport medicines via Royal Mail tracked service. And additional temperature-controlled packaging was used to transport medicines which required refrigeration. But this temperature-controlled packaging was had not validated by the pharmacy for use during extremes of weather so it was unclear whether it was always effective.

There were measuring cylinders to measure liquid. But these looked a little dusty and did not have any validation markings The RP agreed to order new measures and make sure they were regularly cleaned. The RP had access to the internet for reference sources. And there were medicines disposal bins in place.

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.