

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: 26/02/2024

Pharmacy context

THIS PHARMACY IS CURRENTLY SUSPENDED FROM THE REGISTER. THE INTERIM SUSPENSION CAME INTO EFFECT ON 20 MARCH 2025.

This is a distance selling pharmacy located on an industrial estate in Bracknell. People cannot visit the pharmacy in person, and it delivers medicines using a recognised courier. It has an NHS distance selling contract, but this accounts for a very small part of the business. Most of the pharmacy's activity is through its online service operated via dailychemist.com. People can buy a range of over-the-counter (OTC) medicines and health products through the website, and there is an online private prescribing service. People can use the online prescribing service to obtain medicines to treat a range of conditions, including erectile dysfunction, asthma, and weight management. The pharmacy has previously been subject to conditions preventing certain activities taking place.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan; Statutory Enforcement

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 cannot provide sufficient information or records relating to online supplies of Pharmacy (P) and prescription only medicines (POM). This means it cannot provide assurance that it is effectively monitoring its services and managing risks.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacist is not always able to verify that systems and checks are completed properly. So they do not always have appropriate professional control to provide assurances that the services are operating effectively.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's main website does not always contain accurate descriptions about the medicines it supplies. This could be misleading for people using the pharmacy's services.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The responsible pharmacist does not have access to all of the pharmacy's records about the medicines it has supplied. This means they are not always able to make appropriate checks to make sure the medicines that the pharmacy supplies are being used safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy's computer system is set up in such a way that the pharmacy team do not have access to relevant records of online orders and supporting information. This means that the pharmacy cannot effectively demonstrate how it manages risks or monitors its services in keeping with its policies and procedures to help make sure services are provided in a safe and effective manner. The pharmacy has some systems in place to keep people's information safe and it checks their identity when they request to purchase medicines.

Inspector's evidence

The responsible pharmacist (RP) was employed by the pharmacy and worked as the regular pharmacist Monday to Friday. The RP described her role as supervising the dispensing operation. She explained that the superintendent (SI) visited the pharmacy occasionally, but he was not involved in the day-to-day management of the pharmacy. The sole director of the company managed the business. She was not a pharmacist. The management function and customer service team (CST) were not based on the same site as the pharmacy. The RP explained that some members of the CST were based in the UK, and others were based overseas.

The pharmacy had two websites www.dailychemist.com and www.evercaring.uk. Online supplies were generated through [dailychemist.com](http://www.dailychemist.com). The other website, [Evercaring.uk](http://www.evercaring.uk) could not be used to purchase medicines. The RP confirmed that the pharmacy did not supply medicines on behalf of any other websites. The pharmacy mostly supplied medicines to people living in the UK. It worked with two doctors who were registered to practice in Spain. The RP explained that most prescriptions were currently being issued by one of the doctors. As the prescribing service was based overseas it was not monitored or inspected by a UK healthcare regulator.

People ordering medicines via the websites had to create an account using an email address and completed an online questionnaire when requesting both Pharmacy (P) medicines and POMs. The RP explained that orders were received by the pharmacy team through the pharmacy's bespoke computer system. The SI confirmed that the pharmacy used an automated system to complete identity (ID) checks and processed payments. A third-party identity verification provider was used for ID checks.

The pharmacy supplied a wide range of OTC medicines, including treatments for allergies and hayfever, cough and colds, pain relief, and stomach and bowel issues. Medicines supplied included general sales list (GSLs) items and Pharmacy (P) medicines, including high-risk items such as pain killers containing codeine, which are known to be liable to misuse and overuse. The most commonly prescribed items were used to treat erectile dysfunction, asthma, and weight loss.

The prescribers reviewed requests for POMs and if approved, they issued an electronic prescription. The RP explained that prescriptions contained an advanced electronic signature that was unique to the doctor authorising the supply. The pharmacist viewed the orders including the questionnaire responses and copies of the prescriptions on the pharmacy's system. She completed some additional checks, such as checking people's National Care Records (NCR) when supplying asthma and weight loss medicines and approved all medicine requests.

The pharmacy had standard operating procedures (SOPs) and some policies in place for its prescribing services to help manage risks. SOPs had been agreed by the superintendent pharmacist. Team members could access the SOPs online and the pharmacist explained how the system identified when each team member had read them. SOPs generally reflected the pharmacy's working practices but some were not specifically tailored to the business. For example, an SOP describing how the pharmacy supplied OTC medicines made references around provision of advice which were more in keeping with a face-to-face service.

The pharmacy's websites contained contact details and the complaints procedure so people knew how to make a complaint or provide feedback on the service they received. They could also leave reviews online. Complaints were dealt with by the CST. The RP was not routinely involved in resolving complaints. The pharmacy team were contacted if concerns involved orders that had been dispatched, such as wrong items or quantities, and the RP usually discussed any learning points with the team members. She was not aware of the number of complaints that the pharmacy received.

The pharmacy had appropriate professional indemnity insurance. A notice was displayed in the pharmacy identifying the RP on duty. A paper RP log was maintained. The pharmacy had controlled drug (CD) registers, but it had not supplied any schedule 2 CDs within the last two years. It used a recognised patient medication record system to record NHS supplies. And it had a bespoke software system for its online services. Each team member, including the prescribers, had individual login details so actions were attributable to an individual.

Two different digital platforms on which orders were processed were initially seen. But only one of the platforms could be subsequently viewed. This was the one the pharmacist had access to. The second platform appeared to contain different information. The computer system was set up in such a way that the RP could only access a very small number of patient records relating to orders being processed at that moment in time. She could not search the system by patient name, medicine or date. And as soon as orders had been processed, she could no longer view them. Historical records relating to sales of over-the-counter medicines could not be provided. An electronic private prescription record was produced which contained the correct information, but when asked, the RP could not search this system to produce corresponding electronic prescriptions for individual records. Because the RP's access to records and information was restricted, she could not independently interrogate the system to complete additional checks, verify information, or provide assurances that medicines were always supplied safely.

The pharmacy's privacy policy was explained on the websites. It used password protected computers and digital systems. Team members understood that people's personal information should be protected. Confidential paperwork was disposed of using a shredder. The pharmacy had a safeguarding SOP in place and medicines were only supplied to people over 18. Procedures indicated that the pharmacy informed people's GP when supplying medicines which required monitoring such as asthma inhalers and weight loss medicines.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacist relies heavily on checks and assurances being carried out by other team members who are not directly under their supervision. So they are not always able to verify that tasks have been properly completed. And the pharmacy does not always act on feedback provided by the pharmacist. This means the pharmacist does not always have appropriate professional control and is able to provide assurance that the services are operating effectively. The pharmacy generally has enough team members for its workload.

Inspector's evidence

The pharmacy team consisted of the RP, a trainee dispenser and a new team who had only recently started working at the pharmacy and was completing a trial period pending longer term employment. The trainee dispenser confirmed that she was enrolled on a course. She had only managed to complete a few modules since she started working at the pharmacy about nine months ago.

The RP worked as the regular pharmacist five days a week. The pharmacy did not usually use locum pharmacists to provide additional cover. During the week prior to the inspection, the RP had to leave at short notice which meant the pharmacy had to close. This suggested there wasn't an effective contingency plan for unexpected pharmacist absence. Team members worked extra hours if the workload demanded this, for example the RP said she sometimes started working earlier in the day at the beginning of the week when they anticipated a higher volume of orders.

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 CST was responsible for dealing with queries on the phone or by email, and they managed delivery issues, refunds and other non clinical requests. The pharmacist could contact the superintendent for advice if needed but other team members could not. And they were unsure who to contact outside of the organisation if they had a concern.

The CST had not completed any formal pharmacy training, but inhouse training was provided by the director. The director had checked the prescribers' ID and qualifications, and the RP periodically checked their registration permitting them to prescribe. The pharmacist had not met or spoken to the prescribers herself and she usually communicated with them via the director.

The director was in regular contact with the pharmacy, and team members could call her if needed. 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 computer system. The RP 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. She did not know how emails were sent to people's GP, or who was responsible for this so that she could be assured that they had been sent.

The RP, director, and SI attended a monthly video call to discuss any operational issues. The RP felt able to exercise her professional judgement and could refuse to supply orders. She had sometimes provided feedback and made suggestions to the director, but these were not always acted on. For example,

errors or issues with the website listings.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy's main website does not always contain accurate descriptions about the medicines it supplies, which could be misleading for people using the pharmacy's services. The premises are generally suitable for the services provided.

Inspector's evidence

The pharmacy operated two websites: evercaring.uk and dailychemist.com. Medicines could be purchased, and the online prescribing service was accessible through the dailychemist.com website. Both websites contained information about the prescribers and the SI. The dailychemist.com website content was sometimes inaccurate or misleading as some medicines were described incorrectly or did not have any explanations about the conditions they were used for. For example, Nurofen Plus was listed for 'Belching and trapped wind'. And medicines which had been discontinued were still listed, such as Tyrozets.

The pharmacy occupied a small unit in a business premises. It consisted of two small windowless rooms with basic fittings including a desk, work benches and shelving. The pharmacy was reasonably clean although some fixtures were worn in appearance. The pharmacy had one entrance which was locked when not in use. A doorbell system operated so access could be controlled.

Space was quite limited but there was a separate area for the pharmacist to check assembled items ready for dispatch. Some boxes of stock medicines were being stored on the floor, which could pose a trip hazard to members of the team. The pharmacy had a sink with hot and cold running water; however, the sink was stained due to age. An air conditioning unit had recently been installed to help control the room temperature.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy cannot provide assurance that its online service always operates effectively and supplies medicines safely. The responsible pharmacist does not have access to all of the pharmacy's records about medicines that it has supplied. This means they are not always able to make appropriate checks to make sure the medicines it supplies are being used safely. Generally the pharmacy stores and manages its medicines appropriately to make sure they are kept in good condition.

Inspector's evidence

The pharmacy usually operated Monday to Friday 9am to 5pm. The premises was not open to the public. But people accessed its services via the websites. And there was also the option for people to telephone or email the pharmacy. Pharmacy team members had little direct contact with people using the pharmacy's services as most communication was directed via the CST. The pharmacist occasionally communicated with people by email or telephone as people were required to provide a phone number and an email address when registering with the pharmacy to request medicines.

The pharmacy processed a large number of orders each day. People wanting to obtain medicines from the prescribing service were asked to complete an online questionnaire relating to their condition. The prescriber reviewed requests for prescription medicines before deciding whether to issue an electronic prescription. The system transmitted any confirmed orders to the pharmacy. The pharmacist was able to show the information she had been provided with for a small number of orders (fewer than ten) which were in progress. The system informed the RP that ID checks had been completed and allowed her to view the completed online questionnaire responses, the person's order history and the prescriber's comments if relevant. Only one of the records seen had an ordering history. The RP explained how she completed checks when dispensing prescriptions issued by the prescribing service. For example, when people requested salbutamol inhalers, the RP checked the person's NCR to make sure they had a diagnosis of asthma. She described how the pharmacy could supply up to three inhalers at a time and only resupply within a specified timeframe. If she wasn't able to confirm an asthma diagnosis using NCR or another means this, then she rejected the prescription.

One randomly assembled order for Ventolin was checked, but the RP could not access the associated records to show the person's order history, the prescription or what checks had been completed when authorising the supply. She explained she could not search the system for this information and could only view it when authorising it. Similar issues were encountered when checking private prescription records as corresponding consultation records and related prescriptions could not be produced. The RP explained that she could only search the system by order number. But order numbers were not included on assembled orders or the private prescription records. The RP didn't have access to order numbers and was reliant on people knowing their order number if they contacted the pharmacy with a query. This meant the RP could not search for a person's records by name if a GP contacted the pharmacy to discuss a person's ongoing care. Furthermore, it was not possible to view any records relating to supplies of other medicines that the pharmacy commonly supplied, such as weight loss medicines or omeprazole, to show what checks were completed and confirm that these were done consistently.

The RP explained how they informed the person's GP if salbutamol inhalers or weight loss medicines were supplied and how they would usually reject request if people did not or could not provide details

of their primary prescriber. The pharmacy team was not responsible for sending these notifications to GPs. They appeared to be generated automatically by the IT system. The GP notification did not include the quantity of salbutamol inhalers supplied by the pharmacy. The RP could not independently verify these had been sent. She stated that she had never received any feedback or queries from people's GP in relation to these notifications, despite the large number of inhalers supplied by the pharmacy. She showed an example of a request 'on hold' but she didn't have information about how often requests were refused or how she monitored refusals, including people who had been previously refused supplies.

The RP explained how she managed requests for OTC medicines which included confirming ID checks, order histories and completed questionnaire responses. She stated that she would only authorise a supply for a single pack of a codeine containing painkiller. People were only permitted to request two further supplies for a codeine containing medicine with a minimum time interval in between. But the RP could not show instances where this had happened as she could not search the system or provide any information about historical orders for codeine containing medicines.

Medicines were sent to people using a tracked delivery service. Any medicines returned as not delivered were not re-dispensed. The pharmacy used plain, tamperproof packaging to transport medicines. Gel packs were used to transport medicines which required refrigeration. But the RP was not aware if the temperature-controlled packaging had been independently validated by the pharmacy for use during extremes of weather, so it was unclear whether it was always effective.

Stock medicines were stored on dispensary shelves in a reasonably orderly manner. The pharmacy had fridges for storing medicines that required cold storage. The team monitored and recorded maximum and minimum temperatures, to make sure the fridges remained within the correct temperature range. The pharmacy had a small amount of CD stock which was mostly expired. The RP believed the SI was arranging for this to be destroyed. 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 only a single short, dated item was found which was removed for disposal. Obsolete medicine were kept separate from stock. Alerts and notifications relating to medicines safety were sent to the pharmacy's email address and checked by the RP.

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.

Inspector's evidence

The pharmacy had a single computer terminal which was used by the RP, and this was password protected. The pharmacy had a telephone line and handset. Cartons were available for dispensing purposes. The RP had access to the internet for reference sources. And there were medicines disposal bins and a small safe was used to store CDs.

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.