General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dr Fox Pharmacy, 399 Great Western Road, GLASGOW, G4 9HY

Pharmacy reference: 1124326

Type of pharmacy: Internet / distance selling

Date of inspection: 30/05/2024

Pharmacy context

The pharmacy is situated in the West End of Glasgow on a busy high street. It is associated with Dr Fox, an online prescribing service owned by Index Medical Ltd. The pharmacy's only service is dispensing private prescriptions written by prescribers employed by the prescribing service. The pharmacy supplies prescription medicines for hair loss, erectile dysfunction, migraine, malaria prevention and weight loss. People do not visit the pharmacy in person and medicines are sent by post or courier.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy takes steps to identify the risks associated with its services and puts safeguards in place to help manage them. The pharmacy conducts some checks on its processes, but these are carried out ad-hoc, so it may miss opportunities to review the service it provides. Pharmacy team members follow written procedures to help them work safely and effectively. They keep the records they need to by law. And they record and review mistakes they make so that hey can learn from them Then they take action to reduce the risk of further mistakes. The pharmacy keeps people's private information safely and its team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy's main activity was dispensing prescribed treatment accessed via www.drfox.co.uk for a wide range of conditions. These included asthma, erectile dysfunction, urinary tract infections and skin conditions. The pharmacy supplied medicines against prescriptions received by doctors working at a prescribing service separately owned by Index Medical Ltd. The prescribing service was registered and regulated separately by the Care Quality Commission (CQC), a UK health regulator.

The pharmacy had a set of written standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. The SOPs covered tasks such as assembling and labelling prescription items, packing and posting medicines and the responsible pharmacist (RP) regulations. Team members described their roles within the pharmacy and the processes they were involved in. They separated the role of selecting the medication and applying the dispensing label so that two team members were involved in process to help prevent the chance of error. The pharmacy employed a pharmacy technician who worked as an accuracy checker (ACPT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure.

The pharmacy had a risk register for the private services it provided. The register considered the risks involved with the medicines it supplied and providing them from an online service. The pharmacy had not documented all of the steps the pharmacy had taken to lessen these risks. But team members described the risks identified and the demonstrated the actions they took to address these. The superintendent pharmacist (SI) provided evidence showing that they worked with the prescribing service to put a number of measures in place to lessen the risks associated with supplying medicines online. And team members demonstrated the steps they took to address these risks. For example, medication was usually only delivered to people's home addresses. If a person people wanted it delivered to another address, the RP reviewed this and checked to ensure it was suitable by contacting people for more information. And they did not deliver to delivery offices or shared mailboxes. The pharmacy did not supply medication to anyone under the age of eighteen. They also had maximum ages for certain treatments which included oral contraceptives, migraine treatment, and antibiotics for urinary infections. There were extra screening questions asked if people aged twenty-five and under requested medication for erectile dysfunction. This was so that other medical reasons for symptoms could be investigated. The prescribing service also required people to consent for their GP to be notified before they would supply certain medicines. These included oral contraceptives, asthma treatments, traveller's diarrhoea treatment and medicines for weight loss. This provided people's regular doctors

with information about the treatment they received from this service. The pharmacy had placed limits on the maximum quantities of medicines that could be dispensed at a time. And limits on the how often people could receive a further supply. Team members reviewed people's medication history as they dispensed. And they would not dispense any prescriptions that went outside these limits, instead they brought it to the attention of the RP.

The pharmacy did not carry out regular, scheduled audits of the services it provided, or on the supplies of medicines it made to people using its services. But it did complete ad-hoc reviews on the suitability of the medicines provided by the prescribing service. For example, the RP highlighted an increased number of requests for two particular medicines. They brought this to the attention of prescribing team to highlight the possibility of misuse. One of the medicines was removed from the website to prevent people requesting it inappropriately, and they implemented further screening questions and quantity limits for the other. Pharmacy team members checked people's details against existing records when they entered prescription details on the pharmacy's patient medication records (PMR). And they provided evidence of interventions when people had created duplicate accounts using similar details. And they prevented these people obtaining further supplies. The pharmacy maintained a list of addresses which would not be supplied to. This followed team members noticing multiple people trying to use the same address. The RP maintained an intervention log. They demonstrated many examples where they had requested further information from prescribers or people who had requested medication before they completed a clinical check. And they documented the outcome on both the intervention log and the person's medication record. But these interventions relied on team members noticing trends during dispensing and were not carried out in a planned way. So there was a risk that the pharmacy was missing opportunities to review the quality of the dispensing service it is providing. The SI demonstrated how they had regular meetings with the prescribing service, and suggested changes to the service when appropriate. The pharmacy team was consulted if the prescribing service considered prescribing new treatments, and it had provided advice on how to offer these medicines safely. The RP explained the prescribing service did not prescribe injections for weight loss as they felt they were not able to effectively monitor people's ongoing treatment.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as good catches. And they recorded errors that were identified after people received their medicines. The RP reviewed all good catches and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. The team gave examples of changes they had made. This included dispensing medication with similar names in separate batches, to reduce the chance of selection error. The pharmacy had a complaints procedure displayed on the website and welcomed feedback from a variety of sources including TrustPilot, satisfaction surveys, email, and phone. And members of the team knew to provide the contact details for the SI's office if people wished to complain.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. The team kept complete electronic records for supplies of medicines made against private prescriptions and retained the corresponding prescriptions. There were no controlled drug (CD) records as the pharmacy did not supply any of these medicines. The pharmacy's PMR were cloud based, which provided back-up to avoid data being lost.

Team members were aware of their responsibility for ensuring that people's private information was kept securely. They kept confidential waste separately and it was collected by an external company for secure destruction. Team members had been trained on safeguarding vulnerable groups The pharmacist raised any concerns with the prescribers through the customer service team. And they were

registered with the Protecting Vulnerable Groups (PVG) scheme. The pharmacy only supplied to people over the age of eighteen. But it did not carry out any verification of the information provided by prescribers and relied on the prescribing service's identification process being robust.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete appropriate training to keep their knowledge up to date. And they effectively discuss and implement changes to improve their services and make the pharmacy safer. Team members feel comfortable raising concerns with the right people if necessary. And they feel well supported by their colleagues and managers.

Inspector's evidence

The pharmacy employed one full-time pharmacist, four ACPT's, one of whom was the dispensary manager, fourteen dispensing assistants, three of whom were trainee's and the SI who worked in the pharmacy one day each week. One of the pharmacy's directors provided pharmacist cover when needed, for example for annual leave. Typically, the pharmacy operated with an RP and nine other team members. The pharmacy displayed team member's certificates of qualification. Team members were seen to be managing the workload. And those spoken to during the inspection were experienced in their roles. The pharmacy reviewed staffing levels regularly. It used rotas to manage staff levels depending on workload. Part-time team members had scope to work flexibly providing contingency for absence. The dispensary manager delegated set daily tasks to ensure the pharmacy operated effectively. The dispensary team also held monthly meetings to allow discussion around patient safety and operational issues. Team members received planned learning time during the working day to undertake regular training and development. And those undertaking accredited courses were provided additional time to complete coursework. A trainee dispenser was observed being appropriately supervised in their role. Team members had annual appraisals with the dispensary manager to identify their learning needs.

The prescribing team were contactable should the RP or wider pharmacy team need to contact them. The SI had regular meetings with the prescribing service. This ensured that the SI had appropriate oversight of the services offered. The RP used web-based communication software to engage with the prescribing service customer service team and raise clinical queries. There appeared to be a culture where colleagues could seek advice from each other and ask questions if they needed help. The SI showed documented evidence of clinical queries the pharmacy team had raised with the prescribers for advice and guidance.

Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. They felt able to make suggestions and raise concerns to the RP, SI or dispensary manager. The pharmacy had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, and well maintained.

Inspector's evidence

The pharmacy premises was not accessible to members of the public. It was accessed directly from the high street and the door was kept secured at all times to prevent unauthorised entry. The lower sections of the pharmacy’s windows were frosted so that people could not see the activities taking place inside. But the upper half of the windows were clear, so activities could possibly be seen by those at a raised level, for example passing the pharmacy in buses.

The pharmacy was spacious and split over two levels. It had a good workflow with separate areas for processing and labelling prescriptions, packing and assembling medicines, checking, and dispatch. It was tidy and organised with medicines arranged neatly on shelves. And there was a separate staff area which included toilet facilities. There was suitable heating and lighting, and hot and cold running water was available.

People accessed treatment through the prescribing service’s website, www.drfox.co.uk. The website also contained details about who owned the pharmacy, its location and contact details.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has appropriate safeguards in place to help ensure people receive medicines that are suitable for them to take.
It gets its medicines and medical devices from reputable sources. It stores them safely and team members complete regular checks of them to make sure they are in date and suitable to supply.

Inspector's evidence

The pharmacy received prescriptions electronically from the prescribing service via proprietary software. The RP did not see the answers people had entered on the online questionnaire. But prescribers added additional information to prescriptions. For example, when they had asked people for further information about their condition or had provided further advice to people about their medicines. The pharmacy had specific limits on the quantity and frequency of medication dispensed. And team members were aware of these limits. If a prescription was received for a quantity higher than these limits the prescription was held and the pharmacy contacted the prescriber. The RP contacted the prescribing service when they needed to gain further information or clarify information submitted. Multiple examples were seen where the RP had put prescriptions on hold until further information had been received from either the prescriber or the person requesting the medication.

Pharmacy team members followed a logical and methodical workflow for dispensing. Team members printed prescriptions in batches, and the pharmacist then clinically checked each prescription. A team member used the printed prescription to collect stock and used baskets to separate people's medicines. A separate team member created dispensing labels on the pharmacy's PMR by referring to both the paper and electronic copy of the prescription. The medicine was labelled and added to the basket with a shipping label. The ACPT undertook the final accuracy check against the prescription and then a separate team member packed the medicine for delivery. Pharmacy team members used an audit stamp on each prescription and initialled the appropriate box to provide an record of who was responsible for each stage of the dispensing process. Medication was delivered using a national tracked courier service. The pharmacy only supplied medication to addresses in the UK. Any medication that was not successfully delivered was returned to the pharmacy. The pharmacy maintained a record of medication returned before destroying it. The pharmacy team could access this record if people raised a concern regarding failed delivery or requested a further prescription.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. And records showed the fridge was operating between the required two and eight degrees Celsius. The team took appropriate action if the fridge temperature went above or below accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to appropriate reference sources to support the dispensing process. Its facilities protect people's private information.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF). It had access to the internet and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy used discreet packaging for deliveries which meant that people were unable to identify the medicines that were contained within the packages. Team members used passwords to access computers and did not leave them unattended unless they were locked. The pharmacy's portable electronic appliances looked in to be in a suitable condition.

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.