General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Postmymeds, 132 High Street, Whitton, Twickenham, TW2 7LL

Pharmacy reference: 9010203

Type of pharmacy: Internet / distance selling

Date of inspection: 20/04/2022

Pharmacy context

The pharmacy is an independently run internet pharmacy. And it is on the high street in the centre of Whitton. The pharmacy offers a private online prescribing and supply service which it provides through its website https://www.postmymeds.co.uk/. And it delivers medicines to people by post. It has a small, core range of medicines for sale. But customers rarely visit the pharmacy in person. But visitors to the pharmacy were likely to increase as it was planning to introduce an aesthetics service in the forthcoming months. The inspection was conducted during the COVID-19 pandemic after restrictions in England had lifted.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 has suitable procedures in place to ensure its services are safe and effective. And it has adequate procedures for identifying and managing the risks associated with them. The pharmacy effectively reviews and monitors the safety and quality of its services. And it keeps all the records it is required to keep. And it has insurance to protect people if things do go wrong. The pharmacy's team members review the dispensing mistakes they make and learn from them to try and stop them happening again. The pharmacy has adequate procedures for people to provide feedback to help improve its services. And it keeps people's private information safe.

Inspector's evidence

The pharmacy was on the high street. But it provided its services over the internet and so people did not usually need to visit it. The most frequent visitors to the pharmacy were delivery drivers from the pharmacy's wholesalers. The pharmacy had placed hand sanitiser at different locations in the pharmacy for the team and visitors to use. The team had a regular cleaning routine and it had access to personal protective equipment in the form of gloves and masks. The pharmacy had an online private prescription service. And its prescriptions were produced online by one of the pharmacy's pharmacist independent prescribers (PIPs). The PIPs conducted audits of their prescribing service and regularly reviewed their prescribing policies and procedures to ensure that they were appropriate and safe. And to ensure that they were up to date and in line with current guidance and prescribing practice. The PIPs made records on their prescribing system to explain their decision making and the reasons for prescribing or not prescribing a particular medicine.

The pharmacy had produced a risk assessment for its service overall, and it had also risk assessed the potential for people to try and abuse it. Or obtain medicines inappropriately. The pharmacy had processes in place for establishing the identity of people using the service. And it could identify where people were giving them incorrect information about who they were. This helped the team to ensure that the medicines they supplied were appropriate for the people requesting them. The pharmacy's records showed that the team had refused supplies on many occasions when people requesting medicines were identified as not being who they said they were. And where people had given false information about themselves such as their age. The pharmacy also had policies in place to prevent repeated supplies of medicines such as antibiotics when it was clear that the person was not getting the most appropriate treatment for their condition. And where it was clear that a repeat supply was not what they needed or could lead to a further deterioration in health. In these situations people were referred to their GP or an alternative healthcare professional for the appropriate intervention. The responsible pharmacist (RP) made notes on the pharmacy's electronic patient medication record system (PMR) to explain the decision not to supply.

The pharmacy team recorded its mistakes and it reviewed them regularly. The Inspector and the PIP discussed the importance of learning as much as possible from mistakes to help prevent them from happening again. The PIP demonstrated that they had separated stock to draw attention to look-alike and sound-alike (LASA) medicines. It was evident that they had separated Difflam gel and Differin gel in this way to help the team identify the correct one. The RP recognised that records should provide enough detail to monitor mistakes, learn as much as possible from them and promote continued improvement. The pharmacy had standard operating procedures (SOPs) in place. All team members had

read and signed their own copies of the SOPs. The responsible pharmacist (RP) had placed her RP notice on display showing her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. And they could leave a review on the website. The pharmacy's website also gave details of the pharmacy's complaints procedure. And it provided information on how people could contact the team if they had any queries or were experiencing problems with the service. The PIPs could also get feedback through the prescribing system's online chat facility while conducting a consultation. The pharmacy team had received many positive comments from people. It had received positive comments from people who preferred not to have to visit the pharmacy to get their medicines ordered or delivered. The PIPs had also responded to someone who had left negative comments about the quality of the medicines they had received. The PIPs had responded to provide assurance that the medicines were of the same quality as could be obtained at a traditional pharmacy. And they called the person to provide confidential advice and ensure that they were taking the medicine properly. And to establish whether there was anything else which could be affecting the effectiveness of the medicine, such as alcohol intake.

The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 30 November 2022. And it had additional insurance to cover its prescribing services. It is understood that the pharmacy will renew its insurance arrangements for the following year when current insurance cover is due to expire. The pharmacy generally kept its records in the way it was meant to. This included records for private prescriptions and the RP record. The RP recognised that the pharmacy should ensure that all of its essential records are kept in the way they should be.

The pharmacy's team members understood the need to protect people's confidentiality. Confidential paper waste was shredded. People did not generally enter the pharmacy, and delivery drivers did not enter the dispensary, so people's prescription details could be kept secure. And the pharmacy posted people's medicines in plain packaging to ensure that the contents could not be identified as medicines. The RP, PIPs and trainee dispensing assistant (DA) had completed appropriate safeguarding training. Other team members had been briefed. And they knew to report any concerns to the RP or one of the PIPs. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

The pharmacy had a close-knit team who worked regularly together. At the start of the inspection the RP worked alongside a DA and a trainee DA. They were joined part-way through the inspection by both of the pharmacy's PIPs. The PIPs were also directors of the pharmacy business and one was its superintendent (SP). Team members each had their own file which contained their own set of SOPs, their contract of employment details and training information. The inspector and PIP agreed that while a full set of SOPs could be read in one day, it would be beneficial for trainees to read the relevant SOPs again when carrying out the tasks the SOPs related to. Team members were seen to work effectively with one another. And they felt able to raise any concerns with the SP, the PIPs, the RP and their colleagues if they needed to. The daily workload of prescriptions was in hand and people online were attended to promptly. The RP was able to make her own professional decisions in people's best interest. And PIPs followed up-to-date prescribing protocols. They consulted an appropriate medical prescriber on a regular basis to review their protocols and ensure that their prescribing practices were appropriate and up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are tidy and organised. And they are sufficiently clean and secure. The layout of the pharmacy's website ensures that people receive an appropriate consultation before a medicine is prescribed and supplied.

Inspector's evidence

The pharmacy looked like a typical high street community pharmacy. But inside, it had a small reception counter. And it did not have any over-the-counter medicines or pharmacy related goods for sale. The pharmacy had recently extended the size of its consultation room. And the RP proposed to use the space to run an aesthetics clinic. The PIPs currently used the consultation room for the online prescribing service. But they could also do this from other locations in the pharmacy including the basement. The dispensary was relatively spacious. It had a run of dispensing work surface on two sides which provided enough space for the team to work on their tasks. And it had shelves and cupboards for storage. Stock on shelves was tidy and organised. And floors and work surfaces were free from clutter. The pharmacy was air-conditioned, bright, clean and modern. And at the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy's basement provided a further work area and an area for team members to have rest breaks. The premises were of an adequate size for the services provided, and they were secure from unauthorised access.

The pharmacy's website provided all the information it needed to. And its layout complied with GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. People who wanted to use the service first had to log on to the pharmacy's website. They then selected the condition they needed treatment for before completing an online consultation questionnaire. People could view which medicines were available for the condition. And they could read about them. But they would then be directed back to the consultation which they had to complete before any medicine could be selected. While people could express an interest in the medicine they would like, the website made it clear that the final decision about which medicine was prescribed would be the prescriber's. So that the treatment prescribed was the most appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. It gets its medicines and medical devices from appropriate sources. And it stores them appropriately and securely. Members of the pharmacy team carry out the checks they need to. So, they can make sure the pharmacy's medicines and devices are safe and fit for purpose. The pharmacy has sufficient procedures and policies to ensure that its prescribing service is safe.

Inspector's evidence

The pharmacy's website gave its times of opening. And a description of its services and how to access them. The pharmacy did not have an NHS contract. But it offered a private service for prescribing, dispensing and supplying medicines. People accessed the pharmacy's prescribing service through its website. And the service was delivered by the pharmacy's PIPs. The PIPs conducted their consultations with people using the pharmacy's bespoke prescribing service over the internet. Each prescription request generated an appropriate consultation questionnaire. And the PIP monitored each person's answers. Where someone's answers indicated that a prescription may not be appropriate and further intervention would be required, the request was rejected. PIPs, with the support of the other team members, were able to contact people to ensure that they were seeking medicines appropriately. And to direct them to where they would get the care they needed if not. The team were able to detect when someone tried to provide different answers by taking the questionnaire a second time. The PIPs conducted annual audits of their prescribing practice. The audits allowed the PIPs to assess the effectiveness of the whole prescribing process for each medicine. And whether or not people were receiving medicines or advice which supported them to achieve and maintain good health. The PIP described an audit for finasteride where he and his colleagues had assessed whether or not the medicine was working for people and what level of side effects they had experienced. They contacted people after six months of using it in order to find out if it was right to continue prescribing it for them.

The pharmacy supplied a limited range of medicines for a limited range of conditions. Focussing on lifestyle medicines including medicines for migraine, period delay, weight loss, men's health, women's health and sexual health. It delivered prescriptions across the UK but the majority of people using its services lived within the local area. If people had questions or concerns about the medicines they were prescribed, they could raise these via a chat facility on the prescribing system. Or they could call the pharmacy. The chat facility was managed by the DAs with the RP's support, the RP or the prescriber. This was used when a person's order was rejected. But team members often called people to explain why their prescription had been rejected. And to refer them for medical intervention when appropriate. The consultation questionnaires asked people for consent to contact their GPs. While many people gave their consent, some did not. The inspector and the PIP agreed that risk assessments should include any added risks to people's health which could result from the pharmacy not informing their GP.

The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. And patient information leaflets (PILs) were supplied with all medicines. The RP and PIP gave people advice on a range of matters. And would give appropriate advice to people about their medicines. The pharmacy sent its dispensed medicines to people by registered post, aiming to deliver them by the following day. And people had to sign for their medicines when they received them.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately and in their original containers. Stock on the shelves was tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. The team highlighted any items with a short expiry date. And a random sample of stock checked by the inspector was in-date. The team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored items in a fridge as appropriate. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe

Inspector's evidence

The pharmacy had the appropriate equipment for dispensing and supplying medicines. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies.

The pharmacy had three laptops which had been placed at individual work- stations around the pharmacy. And which could be moved around the pharmacy if necessary. Computers were password protected. And team members understood that they should maintain an accurate audit trail and ensure that access to patient records was appropriate and secure.

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.