General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmalogic, 464 Ranglet Road, Walton Summit Centre, Bamber Bridge, Preston, Lancashire, PR5 8AR

Pharmacy reference: 9010938

Type of pharmacy: Internet / distance selling

Date of inspection: 05/09/2023

Pharmacy context

The pharmacy is situated inside an industrial unit which is also used for the owner's 'head office' operations. The pharmacy premises is not open to the public. It dispenses NHS prescriptions for people who reside in care homes. And it supplies medicines in multi-compartment compliance aids for some of the people. It also sells over-the-counter medicines through its website https://www.pharmacyprime.com/. And it provides a prescribing service for an online weight-loss service.

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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. And the pharmacy has safeguards in place to help makes sure that the weight-loss treatments it prescribes are suitable for the people who use them. The pharmacy requests consent to share information with people's GPs, but it was not required for people to use the pharmacy's services. Which means people may not always receive integrated care. Members of the pharmacy team record things that go wrong. And they discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

The pharmacy premises was a large unit on a business park and all pharmacy services were provided at a distance. NHS services and private services were operated independently, but the responsible pharmacist (RP) had oversight over both aspects of the business. A comprehensive set of standard operating procedures (SOPs) was available and covered all aspects of the services provided. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

One of the private services provided by the pharmacy was prescribing weight-loss medicines for people in association with an online weight-loss service, Second Nature. Patients were required to initially undertake a 3-month dietician-led weight-loss programme. If after this period the person was not successful in losing weight in line with their goals, they would complete a questionnaire to be considered for medication to aid weight loss, using semaglutide injections. People who were considered suitable then had an identity check, using the 'Lexis Nexis' software. And people were required to provide consent for the prescriber to view their NHS summary care record (SCR) if they lived in England. If a person did not have a SCR, or lived outside England, the pharmacist independent prescriber (PIP) would telephone them to conduct a consultation over the telephone. 85% of people who used the service provided consent for their GP to be informed about their treatment. However, this was not mandatory. If a person did not give consent, the PIP would telephone them to explore the reasons why not, before deciding whether it would still be appropriate to issue a prescription. This conversation was then recorded on the patient's record.

There were written risk assessments available for the pharmacy's services. Pharmacy-only medicines sold through the pharmacy's website had been risk assessed by the superintendent pharmacist (SI). At the time of inspection, 14 medicines had been risk assessed and approved for sale on the website. The risk assessments included restrictions on the quantity that would be supplied during a period of time. For example, the pharmacy permitted a maximum of three doses of fluconazole thrush treatment to be supplied within three months. But this was not in line with the product's marketing authorisation, which advises caution against people using the medicine on more than two occasions within 6 months. And the pharmacy could not demonstrate how it had reached the decision to allow three doses of fluconazole within three months. Subsequent to the inspection, the SI confirmed that the maximum quantity had been reduced to one dose per person every six months.

The pharmacy implemented a set of security checks to make sure a person placing an order was who they said they were. This included identity checks using the 'Lexis Nexis' identity checking software. There were also automated checks to look for linked accounts, using credentials such as name,

postcode, and email address. The payment system used by the website also blocked use of payment cards linked to 'under-18' accounts. If a person failed an identity check, additional forms of ID would be requested by the pharmacy, such as passport and utility bills.

The pharmacy carried out audits of sales made, to look for potential safety gaps in its systems. For example, the pharmacy restricted sales of promethazine to one pack per household per month. Audits had been completed over a three-month period and the pharmacy had not found any evidence that anyone had managed to circumvent their quantity restriction systems.

The pharmacy team kept records of dispensing errors and their learning outcomes. Near miss incidents were recorded on electronic software. The dispensary manager reviewed the records each month to identify learning. Any individual learning points were discussed with the relevant member of the team. The team was able to give examples of action it had taken to prevent mistakes being repeated. For example, it had moved colecalciferol capsules and tablets away from each other on the dispensary shelves to avoid them being mixed up.

Roles and responsibilities of the pharmacy team were described within individual SOPs. A trainee dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The RP had their notice displayed prominently. The pharmacy had a complaints procedure. Any complaints would be recorded and followed by senior management. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions, and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both were found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team had read the policy, and each had signed a confidentiality agreement. When questioned, a dispenser was able to explain how confidential information was segregated to be removed by a waste carrier. A privacy notice on the pharmacy's website explained how the pharmacy handled and stored people's information. Safeguarding procedures were included in the SOPs. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said he would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a superintendent pharmacist, who was also an independent prescriber (PIP), three pharmacists, three pharmacy technicians who were trained to accuracy check, four trainee pharmacy technicians, 17 dispensers, five of whom were trainees, and three medicine counter assistants (MCA), two of whom were trainees. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team completed a structured introduction programme. They were also provided with additional training, such as training packages for NHS services. Training records were kept showing what training had been completed. But ongoing learning was not provided in a consistent manner. So learning needs may not always be fully addressed.

A training program had been developed by the company for the PIP to complete before they were permitted to prescribe weight loss medicines. The training programme had been developed by prescribing pharmacists, and required a variety of directed reading, face-to-face training and one-to-one assessments. But there had not been any review of the PIP's post-training prescribing or decision making. Which meant the pharmacy could not demonstrate whether the PIP had been prescribing in accordance with its policies.

The PIP kept records of his decision making when reviewing consultations and re-prescribing medicines. This included any referrals back to the dietician team where additional follow up was considered necessary. One record seen involved a patient who wanted to begin weight loss medication, but the consultation indicated they had an eating disorder. The PIP had not prescribed any weight-loss medication and had contacted the dietician team in order to refer the patient to their GP for further support.

Members of the pharmacy team routinely recorded any interventions for NHS prescriptions. The records were made on an electronic system, which allowed for referral and follow up. The outcome of the intervention was recorded on the system and on individual patient records. For example, a GP had been contacted when a patient was concurrently prescribed two types of antidepressants, trazodone and mirtazapine. As a result, one of the antidepressants had been stopped.

The trainee dispenser said they received a good level of support from members of the pharmacy team and the pharmacist. Appraisals were routinely conducted by the pharmacy management. And members of the team held regular meetings about issues that had arisen, including when there were errors or complaints. Team members were aware of the whistleblowing policy and said that they would be

comfortable reporting any concerns to senior management or the SI. There were no performance targets set in relation to professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And the pharmacy's website contains enough information to make clear who is providing the services.

Inspector's evidence

The pharmacy was located inside an industrial unit with offices, meeting rooms, an NHS dispensary, and a dispensary for online services. The premises was generally clean and tidy, and appeared adequately maintained. The size of the pharmacy was sufficient for the workload. The temperature was controlled using electric heaters. Lighting was sufficient. Team members had access to a kitchenette and WC facilities.

The pharmacy sold 'pharmacy-only' medicines through its website https://www.pharmacyprime.com/. The website did not sell any prescription only medicine. It contained information about who owned the pharmacy, the GPhC registration number, and superintendent details.

The pharmacy's prescribing service was used by the website https://www.secondnature.io/. This offered a weight loss service through a subscription model. People could not directly request a prescription only medicine via the website. The website contained the pharmacy and SI's details to inform people about who provided the dispensing service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But the pharmacy does not routinely review people who are taking higher-risk medicines. So it might not always check that the medicines are still suitable, or make sure people are taking their medicines correctly.

Inspector's evidence

The pharmacy premises were not accessible by members of the public. Information about how to contact the pharmacy was available on its website. This information was also provided to care homes who signed up to use the pharmacy's services.

The NHS dispensary had defined areas of work for the care home service. This included an area for labelling and checking prescriptions against the patient medication records (PMR) and dealing with any queries, dispensing medicines, quality assurance, accuracy checking, and packaging. A record of who was involved at each stage was kept. The pharmacy used electronic software and whiteboards to help keep track of when each care home was due their medicines. Information was provided by the care home about the medications required, and any handover notes. If there were outstanding queries from the dispensing process, the pharmacy would inform the care home via email, or as part of the handover note supplied upon delivery. The pharmacist performed a clinical check of repeat prescriptions once every six months and also when there were any medicine changes or new medicines prescribed. Records were kept of previous clinical checks.

The pharmacy used an automated system to assist in dispensing medicines in multi-compartment compliance aids. The system required medicines to be de-blistered in bulk and stored in canisters. The pharmacy had a process to ensure there was prompt turnaround time between de-blistering and being sealed within the compliance aid. And the system recorded details of the manufacturer, batch number and expiry dates of the medicines used.

A delivery service for care homes was available. Signatures were obtained to confirm delivery to the care home, and records were kept in case of a query or concern. A separate signature was obtained for the delivery of any CDs.

Team members were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. And this was recorded on their PMR. But to the pharmacy did not routinely monitor people taking other high-risk medicines (such as warfarin, lithium and methotrexate) to check their recent test results. So they were not able to confirm whether dosages had been appropriately adjusted.

Anyone wanting to purchase a medicine through the pharmacy's website was required to answer a series of questions to determine whether the medicine was suitable for them. A trained member of the pharmacy team reviewed each request and assessed whether the order should be supplied, rejected, or referred to a pharmacist for review. Some orders were automatically referred to a pharmacist, for

example, if there had been recent order of the same or similar medicine, or if the order contained multiple medicines. The pharmacy used intelligent software to 'flag' people's accounts if they were potentially linked to another person. Records of rejected orders for a number of people were seen. The pharmacy team provided an example of a person who had used a number of similar email addresses in an attempt to place multiple orders. The orders had been rejected and the person had been blocked from the website. In another example, the pharmacist had identified a person who had placed multiple orders of senna tablets over a number of weeks. The pharmacist rejected the order, provided a link to the NHS website about constipation, and signposted the person to their GP.

The Second Nature weight loss service that was associated with the pharmacy employed dieticians to provide support to people using the service. Everyone using the service was required to follow a programme of lifestyle changes for the first three months. A person would become eligible for treatment with weight-loss medication if they had not achieved their goals after the three-month programme. The service would then ask the person to complete a questionnaire consultation about themselves, which was initially screened by a dietician. If the person met set criteria, the questionnaire would be sent to the PIP for further assessment. Some patients had consultations via telephone or video. The service relied upon the person using digital scales which linked to their phone via Bluetooth. The pharmacy had set their own eligibility criteria for the service. For example, they did not permit people with diabetes or with a BMI of less than 30 to use the service.

Various consultation notes for prescribed weight loss medicines were reviewed, and they appeared to generally follow accepted consultation methods. The percentage weight loss was calculated and recorded in the consultation notes. The PIP worked in a multidisciplinary team approach with the dieticians involved in the person's care. If a person had not provided a weight via their digital scales, the PIP would alert the service to contact them to provide support. An example was provided of a person being refused a repeat prescription because they had gained weight. The person was referred back to the dieticians for support. Following recent guidance from the Department of Health, in relation to semaglutide shortages, the pharmacy had temporarily stopped taking any new patients onto the service.

When weight loss medicines were prescribed, the prescriptions were dispensed by the pharmacy and sent to people via a courier. A 'PIN' number was sent to the person as an additional verification step. This had to be given to the delivery driver for the parcel containing the medicines to be handed over. The pharmacy had a method to provide cold chain delivery which had been tested and found to be effective for transportation of up to 48 hours. If the delivery was delayed, the pharmacist would contact the patient to assess the situation before giving advice.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked on a three-month cycle. A date checking matrix was signed by staff as a record of what had been checked. Short-dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had remained in the required range for the last three months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received electronically from the MHRA. A record was kept of when the alert was received, showing how it had been actioned and by whom.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

The pharmacy used an automated system to prepare the compliance aids. They had a maintenance contract for a monthly maintenance and deep clean. And team members cleaned down the system at the end of each day.

Computers were password protected and information was not visible from outside of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

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.