General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: mychemistplus Pharmacy, 327 Halliwell Road, Bolton, Greater Manchester, BL1 3PF

Pharmacy reference: 9011081

Type of pharmacy: Internet / distance selling

Date of inspection: 08/07/2021

Pharmacy context

This is a pharmacy which offers its services to people in the UK through its website (www.mychemistplus.co.uk). People cannot visit the pharmacy in person. The pharmacy has a prescribing service provided by a pharmacist prescriber. The website offers prescription medicines for a range of conditions, but the pharmacy mainly supplies antibiotics for dental care and asthma inhalers. The inspection was undertaken during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: 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	1.1	Standard not met	The pharmacy does not identify and mitigate all the risks associated with the services it provides. Risk assessments are incomplete and they are not used effectively to make sure risks are managed.
		1.6	Standard not met	The pharmacy's private prescription records are inaccurate. Consultation records are inadequate, and they do not contain enough verified information to justify prescribing decisions.
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 not all met	4.2	Standard not met	The pharmacy supplies a large number of asthma inhalers. It is not able to demonstrate that safeguards are in place to make sure the medicines it supplies are clinically appropriate. This includes confirming a diagnosis, verifying the information provided by the person completing the online questionnaire, sharing all relevant information about the prescription with the person's regular doctor, and ensuring effective monitoring is in place.
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 identify and manage all of the risks involved with its services, particularly in relation to its prescribing of asthma inhalers, which it supplies in large quantities. This means that there are some risks to patient safety. The pharmacy's private prescription records are inaccurate and consultation records lack detail, so it cannot clearly demonstrate it is supplying medicines safely. The pharmacy has written procedures on keeping people's private information safe and protecting the welfare of vulnerable people

Inspector's evidence

The superintendent pharmacist (SI) was the regular responsible pharmacist (RP) and her name was displayed in the pharmacy. She was a pharmacist independent prescriber (PIP) and she provided the pharmacy's prescribing service as well as supervising dispensing activity. The pharmacy had standard operating procedures (SOPs) for the services provided which had been prepared by the SI.

The pharmacy mainly supplied inhalers and antibiotics. The SI believed people used the service for convenience or because it was less expensive than going to their own GP. She thought the increase in demand for antibiotics for dental care was because it was harder to get an appointment with their own dentist during the Covid-19 pandemic. The SI explained that the business model was based on repeat prescribing. She said she did not diagnose and only supplied the medicine if the patient had been previously prescribed it by their GP. However, she supplied medicines for dental infection which required a diagnosis. It was necessary for her to identify poor asthma control which is essential when prescribing inhalers. Making these assessments was difficult within the constraints of an online consultation. The risk of people not correctly reporting details in the online consultation or falsifying their diagnosis was included in risk assessments. But apart from a patient identity check, the SI did not take any steps to verify the information provided or confirm a diagnosis, so these risks were not effectively managed.

There were basic risk assessments on dispensing, delivery and returns. But these did not cover the additional risks created by the SI's dual role of prescriber and supplying pharmacist, and the absence of a second check for clinical appropriateness. There were risk assessments for each category of prescription only medicine (POM) supplied. But some of these had not identified all the associated risks. For example, the assessment for asthma did not identify the risk of a person having poorly controlled asthma, which should be a red flag leading to a referral. People not using their asthma inhaler properly was identified as a hazard, but the risk control was simply asking the patient if they knew how to use their inhaler. More robust controls such as a video call to check inhaler technique had not been considered. The risk of supplying weight loss products without physical examination, to vulnerable people with eating disorders had not been considered in the weight loss risk assessment. The SI said she would carry out a video call if she received an order for a weight loss product, so she could see the person, and have a visual confirmation of their weight. However, this was not recorded in the risk assessment and no video calls had taken place.

There were prescribing policies to help with prescribing decisions and these also included counselling, follow up and monitoring. The SI said she had not provided any verbal counselling, although some written information was provided when the medicine was supplied. So these policies were not followed

in practice. The name of the person who had written the prescribing policies and completed the POM risk assessments had not been recorded, and the SI had not signed to say she had approved them. The SI explained that she prescribed from a limited formulary of medicines, which she felt were within her competence and were appropriate to supply via an online consultation. For example, she had decided to stop supplying steroid containing creams such as Betnovate and Fucibet as she felt it was difficult to treat skin conditions online. She stated she didn't prescribe anything off license and followed UK national prescribing guidelines such as National Institute for Health and Care Excellence (NICE), British National Formulary (BNF), and the Summary of Product Characteristics (SmPC) from the electronic Medicine Compendium (eMC). The SI had not carried out any prescribing audits because she was the only prescriber and she felt that her prescribing was always in line with this guidance. And she had not considered getting another qualified person to regularly audit and monitor her prescribing to mitigate some of the risks of working alone. The SI used the online consultation as her consultation notes, as she felt that all the information required to make a prescribing decision was included in the questions. If she decided not to prescribe then she would record the reason in the notes on the 'back end' of the computer system, and she recorded 'encounters' with patients, such as phone calls, as part of the consultation history. But the reasons for her prescribing decisions and arrangements for follow-up and monitoring were not included in the records, which might impact the continuity of care.

Customers wishing to purchase over-the-counter (OTC) medicines via the internet were required to complete relevant questions which included the WWHAM questions. Pharmacy medicines were offered for sale on the website, but higher-risk medicines such as codeine containing medicines and sedatives were not available. The SI did not feel it was appropriate to supply these types of medicines online and she stated the pharmacy had not supplied any OTC medicines.

There were no documented dispensing incidents and the SI confirmed there had not been any dispensing errors. Two or three near misses were recorded on a log. Actions to prevent reoccurrence had been recorded such as to take a mental break between picking and labelling. A complaint procedure was displayed on the website and 'contact us' details which included the pharmacy's phone number and email address. Trust Pilot was used to monitor customer service and the pharmacy had a 'trust score' rating of 4.6 out of 5.

A current certificate of professional indemnity and liability insurance was available in the pharmacy. The SI confirmed it covered all the activities including prescribing, and the insurance provider was aware she was carrying out both the role of prescriber and pharmacist. The sample of RP records viewed indicated that the SI was always the RP. There were no absences recorded. Private prescription records were not accurately recorded on the Patient Medication Record (PMR) system. The SI could not produce a complete record of the prescriptions the pharmacy had supplied. The SI contacted the PMR provider following the inspection for help to rectify this issue and subsequently produced an accurate report.

Everyone using the website had their identity (ID) screened by a third-party provider. The SI explained that it checked the name and date of birth against the electoral role records and she cross-checked this with payment details. She described this as a 'soft' identity check and explained there was a facility on the website so people could upload photo ID. She requested this if she felt additional information was required, to make the ID check more robust, but she had not used this facility. An example was shown of a person being declined a prescription because they failed the ID check as a result of an incomplete address, and they could not be contacted on the phone number they had provided. People using the pharmacy's services were required to complete 'patient registration' and read the terms and conditions. The pharmacy's privacy policy was available on the website. There was a confidentiality clause for staff. The security of the website was assured by Hypertext Transport (or Transfer) Protocol (http) and 'Global sign' Secure Sockets Layer (SSL).

The SI had completed level 3 training on safeguarding children and vulnerable adults. People not reporting their correct sex, pregnancy/breastfeeding status or correct age and identity was highlighted in the risk assessment for contraceptives and emergency hormone contraceptives (EHC) as a safeguarding concern. The risk controls implemented for this included cross checking the questions on the consultation with the patients' identification check, reinforcing the importance of answering the consultation accurately and a telephone call with the patient following the online consultation. There was a safeguarding SOP and the contact numbers of who to report safeguarding concerns to in the Bolton area was available, in case of a local query. The SI would look up the relevant details if she had a safeguarding concern in a different part of the country.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small close-knit team. Team members have the right qualifications for the jobs they do. The pharmacist prescribes, dispenses and self-checks all of the prescriptions that the pharmacy supplies. This may increase the risk of errors as there is no second professional check for clinical appropriateness and accuracy.

Inspector's evidence

The SI was qualified as an independent prescriber. She stated she was close to finishing an advanced practitioner course at university and had completed modules on clinical examination skills, biological basis of disease, clinical diagnostics disease and safeguarding. She explained that she had experience as a practice-based independent pharmacist in an NHS GP practice, where she prescribed and held asthma clinics. She considered herself competent in all of the treatment areas offered on the website and in particular long-term conditions such as asthma, as well as acute medicines including antibiotics. The SI had completed the Centre for Pharmacy Postgraduate Education (CPPE) training on Summary Care Records (SCR). She had also recently completed Health Education England (HEE) introduction to antimicrobial resistance and toolkit, antimicrobial stewardship for community pharmacy and antibiotic review. She had also taken the antibiotic guardian pledge.

The SI currently prescribed and dispensed each prescription herself. The dispenser could be called into work if necessary, however the SI indicated this rarely happened. The SI also carried out the clinical and accuracy checks. This introduced an element of risk, as a second suitably competent person, rather than the prescriber, should usually be involved in carrying out the final accuracy check and the check for clinical appropriateness. The SI said she minimised this risk by prescribing during the day and assembling and checking in the evening. This gave her a mental break between prescribing and clinical checking.

The dispenser had completed an NVQ2 equivalent qualification in dispensing and had completed modules on long Covid, fungal nail infections and headache during the last year via the NPA training hub. The team members discussed issues informally as they arose and the pharmacy had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare services from. But some parts of the pharmacy's website are misleading and unprofessional, and it does not clearly provide the name and address of the prescriber. This means people may not have enough information to make an informed decision about their care.

Inspector's evidence

The pharmacy was situated in a secure, closed unit on the first floor of a commercial building. The pharmacy premises were in a reasonable state of repair and the fixtures and fittings were in fairly good order. The temperature and lighting were adequately controlled. The team had access to a private kitchen area, where there was hot and cold running water and a WC with a wash hand basin. There were a couple of separate offices on the first floor which were not part of the registered premises and the SI confirmed they were unused. Access into the premises was via a locked door on the ground floor, and people needing access such as wholesale drivers, were required to ring a bell to gain entry.

A new website layout had been recently launched which was aimed to prevent people selecting the medicines they wanted, and the quantity, before they had an appropriate consultation with a prescriber. The website was much more consistent with GPhC guidance than the previous layout. However, there was a video clip on the website which was misleading as it described the process incorrectly indicating a person could choose a treatment and then complete an online consultation. Some terminology on the website was transactional such as 'buy asthma treatments', which detracted from the professional image. The pharmacy advertised 'Blue Inhaler For Asthma - 2 For Only £12.50' which was unprofessional and could encourage inappropriate use of medicines. There was also an issue where a list of medicines appeared which could be added directly to the basket, without a consultation, at the end of the blog and when the consultation for another medicine was submitted. Following the inspection, the SI confirmed that this had been reported to the website providers and they were working to resolve this issue.

The pharmacy's GPhC registration number could be seen on the GPhC voluntary logo displayed on the website. The SI's name and registration details were displayed on the website. In one part of the website there was a statement that the pharmacy's prescribers were 'Independent Prescribing Pharmacists', but the name of the prescriber and how to check their registration status was not clearly displayed. The SI pointed out that people were informed of the prescriber's name when they completed their order and when the consultation was being reviewed and authorised. People could then communicate directly with the prescriber via a chat feature, which was part of the aftercare service, and this provided an audit trail of communication between the patient, prescriber and pharmacist. The patient could monitor the status of their prescription via this facility. Following the inspection, the SI provided screen shots showing this facility for a sample patient.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy’s working practices are not always safe and effective. It supplies medicines without informing the patient's regular doctor, and the prescribing relies solely on information provided by the person completing the online questionnaire. This means people may receive medicines that might not be clinically appropriate, and their condition might not be properly monitored and controlled. The pharmacy generally sources and stores medicines safely.

Inspector's evidence

Services provided by the pharmacy were outlined on the website and people could communicate with the pharmacist via telephone, email, live chat or a messaging system accessed via their account. There was very little health information available on the website. Two healthcare blogs had been posted on the website during 2019 and 2020. The SI explained that she intended to post two blogs every month targeted on healthy lifestyle and asthma. People were advised to read the patient information leaflet which was supplied with medicines and some additional written information was sometimes included. For example, additional information was sent in a letter with metronidazole which advised people to complete the course, not to drink alcohol and it contained information about contraception. A letter was available to send out with some other prescription medicines informing the patient to arrange to have their blood pressure tested as the previous reading was six months ago and a new reading was required when ordering medication next time. Other letters were available such as one advising the person that if their symptoms persisted or worsened, they must book an appointment with their GP. The SI had not provided any verbal counselling or advice about medicines but said she would make a note on the consultation records if this was necessary.

The SI confirmed that dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Assembled prescriptions were posted using a special delivery Royal Mail service. This was a signed for service and could be tracked by the pharmacy. The pharmacy had supplied a large number of inhalers over the last six months and on many occasions six inhalers had been supplied to the same person at one time. The SI said she allowed six inhalers at a time to reduce the postage and packaging costs for people. She said if a person ordered six inhalers then they would not be allowed to order any more inhalers for at least 3 months, as the maximum the SI allowed was an average of two inhalers each month. However, records indicated that there were a number of occasions when people had received excessive quantities of inhalers indicating their asthma was not under control, and they had not been referred to their primary care provider for review.

People were asked for the contact details of their GP and consent for the pharmacy to contact them to share the information about their online treatment, but the pharmacy had not informed anyone's GP when it made supplies of medicines. The SI explained that she had organised access to Summary Care Records (SCR) as a way of checking that the information provided during the online consultation was correct, including the GP's details, but she was not using this facility. So there was a risk that people could receive medication which was not clinically appropriate or that their condition might not be monitored. Consent to access SCR was currently covered in the terms and conditions and privacy information on the website, but this was not effectively obtaining explicit consent, so there was a risk that a person would agree to this without knowing.

Reasons for declining prescriptions had previously been recorded in a book with details of follow up phone calls. For example, a person was refused a supply of amoxicillin for a dental abscess as they had already just taken a course of amoxicillin, and they didn't have a regular dentist. The SI explained in a phone call to this person that she would not be able to supply another prescription and signposted them to emergency dentists in their area. Another prescription was declined as twelve asthma inhalers had been requested by the same person. The SI said when prescriptions were declined the person was always signposted to another relevant service.

The SI stated that all supplies were recorded on individual patient medication records so that they could be monitored, and the records included the questions that had been asked and the responses that were received. The SI explained that she checked these records to help her identify inappropriate requests such as multiple or frequent orders. However, these were manual checks and the system did not automatically monitor or flag these requests. This relied on the vigilance of the SI to spot any issues and so there was a risk that inappropriate requests might be overlooked.

There were two prescribing policies for dental infections covering metronidazole and amoxicillin. The risk of antibiotic resistance was controlled by not prescribing more than once in six months and carrying out a follow up call after three days to check treatment had been effective. If there had been no improvement, they were referred to their dentist as soon as possible for a possible lab culture. The prescribing policies and risk assessments were new and follow up calls were not happening in practice. The SI stated that she did not allow more than one supply of metronidazole or amoxicillin within six months, which she felt was in line with good antimicrobial stewardship. All antibiotic supplies were for dental care and the patient had to confirm they had made an appointment with a dentist during the online consultation. A letter was sent with antibiotics for dental care reminding the person that they had agreed to consult their dentist as part of the consultation and stating that a repeat order would not be allowed in the next six months. The pharmacy offered the weight loss product orlistat. The SI confirmed that none had been supplied. There was a prescribing policy and risk assessment for this. A follow up was required after three months to check that the patients' weight loss was at least 5%, as part of the monitoring required.

Space was adequate in the dispensary. The only stock in the pharmacy was metronidazole tablets, amoxicillin capsules, Ventolin inhalers and Salamol inhalers. It was stored in dispensary drawers, which were well organised, neat and tidy. Medicines were obtained from recognised licensed wholesalers and stored in their original containers at an appropriate temperature. No medicines requiring refrigeration were supplied by the pharmacy and there was no medical fridge. No controlled drugs (CDs) requiring safe storage were supplied by the pharmacy and there was no CD cabinet or CD register. Alerts and recalls were received via email messages from the Medicines & Healthcare products Regulatory Agency (MHRA).

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information including the electronic BNF. IT provisions were outsourced. All electrical equipment appeared to be in working order. PMRs were password protected. There was a separate prescribing portal which only the prescriber had access to. All medicines were supplied in original packs so there was no measuring or counting equipment.

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.