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: 26/09/2022

Pharmacy context

This pharmacy 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.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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	1.2	Standard not met	The pharmacy does not complete clinical audits, monitor compliance with policies or seek input from a second clinically competent person to ensure prescribing is safe and appropriate.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website is arranged so that a person selects a prescription only medicine (POM) before starting a consultation with a prescriber.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacist does not have sufficient oversight of stock ordering and management.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy has some risk assessments and prescribing policies which assess some of the risks associated with its services. But it does not monitor compliance with policies or complete clinical audits to make sure its services are safe, and prescribing is appropriate. The pharmacy team protects people's private information and the pharmacist has completed training on protecting the welfare of vulnerable people.

Inspector's evidence

The superintendent pharmacist (SI) was a director of the company that owned the pharmacy. She 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 SOPs had been recently reviewed and the dispenser, who was the only other member of the pharmacy team, had signed to indicate he had read and accepted them.

The SI explained that she prescribed from a limited formulary of medicines, which she felt were within her competence and she followed UK national prescribing guidelines such as National Institute for Health and Care Excellence (NICE), the British National Formulary (BNF) and the electronic Medicine Compendium (eMC). The pharmacy's records indicated that it mainly supplied the antibiotics amoxicillin and metronidazole to treat dental abscesses. The pharmacy’s records showed that since 1 March 2022 only these two medicines had been supplied; around 90% of the prescriptions were for amoxicillin 500mg capsules. The SI undertook the roles of prescriber and supplying pharmacist. The pharmacy had not carried out any prescribing audits or monitoring of compliance with policies to make sure prescribing was safe. And the pharmacy had not considered getting another clinically qualified person to monitor prescribing in order to mitigate some of the risks created by working in clinical isolation.

Medicines were prescribed following the completion of an online consultation. The SI 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. She said she used this when required if the person had consented to this. However, explicit consent to access SCRs was currently only included in the dental consultation. The SI said she would send a separate communication to somebody requesting other types of medicine if she felt it necessary to access their SCRs and they had not previously provided consent for this.

There were risk assessments for each category of prescription only medicine (POM) offered. These aimed to identify the different areas of risk for each service it delivered and a plan to mitigate them. The risk of antibiotic resistance when prescribing metronidazole and amoxicillin was controlled by not prescribing more than once in six months. The SI felt this was in line with good antimicrobial stewardship. The SI checked for repeat requests when reviewing the consultation before issuing a prescription, and the dispenser checked when labelling the prescription on the patient medication record (PMR). There were no audits to demonstrate that inappropriate ordering was always picked up. However, a search of the antibiotics supplied in the previous seven months did not identify any repeat supplies. The SI checked local antimicrobial clinical guidelines as she prescribed for people in all parts of

the UK, and currently amoxicillin was first line in all areas of the UK due to better compliance over penicillin.

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. This would be to mitigate the risk of supplying weight loss products without physical examination, to vulnerable people with eating disorders. She did not supply any injectable preparations, such as Saxenda, as she felt the risk of supplying these following an online consultation was too high.

The pharmacy's website listed propranolol as a treatment for situational anxiety. This was supplied following an online consultation. The SI said she had not received any requests for this medicine, but she would have checked the patient's SCRs to verify the information they provided before making a supply. She also stated she would inform their usual prescriber about the supply. The SI agreed to remove propranolol from the website when it was highlighted that this was a high-risk medicine, and she confirmed that she had done this the following day.

There were prescribing policies to help with prescribing decisions and these included counselling, follow up and monitoring. The SI said she reviewed the risk assessments and prescribing policies regularly to reflect the most recent best practice clinical guidelines. But admitted some aspects of the prescribing policies needed updating to reflect the questions included in the online consultations. The pharmacy's prescribing policy for amoxicillin and metronidazole was updated post inspection and forwarded to the inspector.

Consultation records were kept electronically, and these were based on the online consultation and any additional communication between the prescriber and patient. The pharmacy requested consent to notify the patient's GP as part of every online consultation, and if consent was received, an email was sent to notify the GP of the service and the treatment supplied. These notifications were attached to the consultation records. The SI said if she decided not to prescribe then she would record the reason in the consultation records, but there had not been any refusals in the last three weeks.

There was a patient safety report template to report dispensing incidents. There were no completed reports. The SI confirmed that there had not been any dispensing errors. Two or three near misses had been recorded on a log, but nothing had been recorded in the last year, so the team might be missing out on additional learning opportunities. There was a 'contact us' section on the pharmacy's website for electronic communication with the pharmacy and it included the pharmacy's phone number and email address.

Current certificates of professional indemnity and liability insurance were available. The SI confirmed the insurance covered all the activities including prescribing, and the insurance provider was aware she was prescribing antibiotics for dental care. The sample of RP records viewed indicated that the SI was always the RP. Private prescription records were electronic.

Everyone using the website had their identity (ID) screened by a third-party provider, and medicines were not supplied to anyone under 18 years of age. People using the pharmacy's services were required to complete 'patient registration' and read the terms and conditions. The pharmacy's privacy and cookies policy was available on the website and there was a General Data Protection Regulation (GDPR) SOP. There was an information governance SOP which included information on confidentiality. Confidential waste was collected in a designated place and shredded. The SI confirmed that the website was appropriately secure.

The SI had completed level three 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 and clinically 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.

Inspector's evidence

The SI was a qualified PIP and completed an advanced practitioner qualification in February 2022. As part of the MSc Advanced Clinical Practice course the SI had completed modules in clinical examination skills, biological basis of disease, diagnostics and therapeutics, leadership, delivering quality improvement in practice, and end point assessment. The SI explained that during the prescribing course, she had experience as a practice-based pharmacist in an NHS GP practice, where she prescribed and held clinics, under the supervision of a medical doctor. She considered herself competent in all of the treatment areas offered on the website, including dental care. The SI had completed the Centre for Pharmacy Postgraduate Education (CPPE) training on SCR. She had also completed Health Education England (HEE) introduction to antimicrobial resistance and toolkit, antimicrobial stewardship for community pharmacy and antibiotic review. She had taken the antibiotic guardian pledge.

The SI prescribed during the morning and assembled and checked prescriptions in the evening. This gave her a mental break between prescribing and clinical checking. But the pharmacy's procedure did not include a second professional check or a system to independently review the prescriber's performance and check their skills and competence.

The dispenser had an NVQ2 qualification. The team members discussed issues informally as they arose, and the pharmacy had a whistleblowing policy.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises provide a professional environment for people to receive healthcare services from. But the website layout allows people to select a prescription only medicine before having a consultation with the prescriber. This increases the likelihood that people may sometimes receive medicines which are not necessarily suitable for their needs.

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 pharmacy was clean and a cleaning matrix was used to ensure all parts of the pharmacy were cleaned on a regular basis. 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. 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 launched three weeks previously. It was intended to be more user friendly and secure. But it was possible for people to select a prescription only medicine before they had an appropriate consultation with a prescriber, which was not consistent with GPhC guidance. Following the inspection, the SI confirmed that the ‘start consultation’ buttons had been removed from individual medicines. However, it was still possible to start the consultation from an individual medicine. Some of the terminology on the website was transactional such as 'add to cart', which detracted from the professional image.

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 and it was made clear that she also prescribed for the pharmacy.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy sources medicines appropriately, but the pharmacist does not have sufficient oversight of stock ordering. This means medicines might not be effectively managed and stored securely. The pharmacy offers its services online, so they are easy for people to access. It mainly uses consultation questionnaires to determine if treatment is suitable, and it could do more to verify information or make extra checks to ensure supplies are appropriate.

Inspector's evidence

Services provided by the pharmacy were outlined on the website and people could communicate with the pharmacist and prescriber via telephone, email, or a messaging system accessed via their account. This provided an audit trail of communication between the patient and prescriber. The patient could monitor the status of their prescription via this facility. There was very little health information available on the website apart from a few healthcare blogs. People were advised to read the patient information leaflet which was supplied with medicines. 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 online consultation for dental abscess included patient history, their allergy status and the presenting symptoms. It checked for red flags and included the appropriate safety netting. The consultation questions correlated with NICE guidelines and the questions were reviewed in line with updated clinical guidelines. The consultation aimed to determine that the person was suffering from a dental emergency and they were unable to see a dentist, but there was no verification of the information provided and the SI was not able to show evidence of any refusals from the previous three weeks. The person was informed to contact the pharmacy if there was no improvement in their symptoms and arrange a review with a dentist if they had not already done this. This was sent in a follow up message.

Customers wishing to purchase over-the-counter (OTC) medicines via the internet were required to complete relevant questions which included the WWHAM questions. Pharmacy (P) medicines were offered for sale on the website, and the higher-risk medicine Solpadeine plus, which contained codeine and could be misused, was available. The SI said this was an error introduced when the new website had been set up three weeks ago. She said she had not realised it was there and she immediately removed it following the inspection. The SI stated the pharmacy had not supplied any OTC medicines. There had been a few requests for medicines, but she had not been able to supply them because they were out of stock at the wholesalers. For example, Brolene eye drops.

Space was adequate in the dispensary. There were over twenty drawers for dispensary stock. They were all empty apart from two drawers which contained metronidazole tablets and amoxicillin capsules. The SI confirmed that there was no other stock in the pharmacy and said she would order if a request came in for a medicine which was not in stock. A cupboard which the SI had previously said was used to store excess stock in was locked. The SI was not able to open it during the inspection, as she said she did not have the key. However, she stated there was no stock in it. The SI confirmed that medicines were obtained from a recognised licensed wholesaler, but there were no invoices available in the pharmacy to verify this. Following the inspection, purchasing history was obtained from the

wholesaler which indicated a variety of POMs, including propranolol, had been obtained since 1 March 2022, which had not been prescribed and were not in stock at the inspection. And a large number of amoxicillin packets had been ordered in excess to the quantity supplied. The SI subsequently explained this stock was being stored in the locked cupboard, but she had been unaware of these orders as all stock ordering and management was done by the dispenser.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. 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. Equipment is appropriately maintained and used in a way which protects people's privacy.

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.