

Registered pharmacy inspection report

Pharmacy Name: Webmed Pharmacy Ltd, Pentland House, Suite 4,
Village Way, Wilmslow, Cheshire, SK9 2GH

Pharmacy reference: 9011118

Type of pharmacy: Internet / distance selling

Date of inspection: 22/10/2021

Pharmacy context

The pharmacy is in an office building in the town of Wilmslow in Cheshire. It provides private services that people access through its website. This includes an online prescribing service for conditions such as erectile dysfunction and weight management. The pharmacy provides a range of diagnostic test kits and treatments. This includes for sexually transmitted infections (STIs) and Group B Streptococcus (GBS) testing. People do not physically go to the pharmacy and it delivers all its medicines and diagnostic tests to people's homes. This inspection was completed during the pandemic.

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 met	1.2	Good practice	The pharmacy is good at monitoring the quality of its service provision. It does this by robust auditing and appropriately acting on the information from these audits. Pharmacy team members thoroughly investigate mistakes and are good at learning from them.
		1.6	Good practice	The pharmacy keeps thorough records of clinical interventions and prescribing rationale. Team members and prescribers use these records to help give effective care to people accessing services. And team members keep easy-to-access records of order cancellations. This helps the pharmacy monitor the appropriateness of the medicines people receive.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	People who access the online prescribing service through the pharmacy's website can complete the selection of a medicine and quantity before completing a consultation for their condition. This is not in line with GPhC guidance. And people can amend the answers in the consultation questionnaire without the pharmacy and prescribers having a record of any changes.
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 suitably identifies and manages the risks with its services. And it mostly has an anticipatory approach to identifying and managing risk. Team members follow a thorough clinical governance written procedure to help them provide safe services. The pharmacy is good at monitoring the quality of its service provision. It does this by robust auditing and appropriately acting on the information from these audits. Pharmacy team members thoroughly investigate mistakes and are good at learning from them. The pharmacy keeps the records it needs to by law. And it keeps thorough records of interventions. Team members and prescribers use these records to help give effective care to people accessing services. Team members keep people's private information secure. And they understand their role in helping support vulnerable people.

Inspector's evidence

The pharmacy had identified risks at the start of the COVID-19 pandemic associated with infection control. People did not access the pharmacy premises directly, so infection control measures protected team members. The building had hand sanitiser at the entrance and the pharmacy also had hand sanitiser available. The pharmacy had separate workstations at the start of the pandemic for different team members to help with social distancing. It had adjusted the requirements throughout the pandemic in line with risk of transmission. This included allowing courier and wholesale delivery drivers into the pharmacy premises when cases were lower and government restrictions eased. The team members had personal protective equipment (PPE) and team members donned face masks once the inspectors accessed the pharmacy.

The pharmacy provided private services including using a CQC registered online prescribing service. People accessed services through the pharmacy's website. People completed an online consultation questionnaire and submitted this to the pharmacy. The pharmacist completed an initial review, contacting the person for additional information if necessary and then submitted it to the prescriber for review. The prescribers worked remotely and had an encrypted log-in that no-one else could access. And they sent prescriptions as a pdf so no alterations could be made. The pharmacy had standard operating procedures (SOPs) relevant to its services, including for clinical governance of the online prescribing service. The pharmacy had other required SOPs such as responsible pharmacist (RP) regulation SOPs. The SOPs had version control and the date of last review documented within the SOP. The SOPs had been reviewed in March 2021. Team members, including the regular locum pharmacist, had read the SOPs in 2021. They recorded this with a signature and date of reading. Team members were seen working safely and following aspects of the SOPs that had been checked by the inspector. Pharmacy team members were seen completing appropriate tasks for their roles and appropriately referring queries to the pharmacist when needed. The pharmacy was open when the inspectors arrived, and the superintendent (SI) arrived a short time after and signed in as RP. The pharmacy had two dispensers on site prior to this. They were aware of what they could and couldn't do when the RP wasn't signed in. They were working within the RP regulations prior to the RP signing in.

The pharmacy had completed written risk assessments (RA) for its services, and these were available in the pharmacy to refer to. There were RAs for most of the medicines the pharmacy supplied. The clinical governance SOP adequately addressed the seven pillars of clinical governance and supported the team to help provide its services safely. This SOP enabled the pharmacy to proactively assess its services

before new services were introduced. This provided an anticipatory approach to risk identification and management. The RAs seen had been completed in 2017 and were suitable in assessing the risks to pharmacy services. By introducing a regular review of the RAs, the pharmacy could identify any changing risks. The RAs covered a wide range of potential risks that suitably identified the key risks. The pharmacy had a good understanding of the risks surrounding supplying medicines online to vulnerable people. The pharmacist contacted the person if they had concerns. The pharmacy could emphasise this understanding of vulnerability in its RAs.

The pharmacy kept a dashboard spreadsheet to track the review dates of its policies including for the different conditions it offered treatment for. The dashboard also documented the review dates of the online consultation questionnaires. This included who had agreed the update and why it was necessary. Several updates were attributed to changes in clinical guidance. This dashboard provided an audit trail of changes and helped ensure the clinical content was adequately monitored. The pharmacy reviewed the consultation questionnaires using NICE guidance and other clinical resources, for example British Association for Sexual Health and HIV (BASHH). The pharmacy completed ongoing clinical audits, although through the pandemic this had been reduced. During the inspection four clinical audits and one re-audit were seen. These had clear assessment criteria against a relevant set of standards and had appropriate methodology for data collection. One audit for the gonorrhoea treatment pack had identified a low uptake of the free test of cure, which was an important part of the treatment. Following these findings, the team made some changes to processes. These included stamping the date on a printed note of when the person was to complete the test to cure. A team member then added the note to the pack during dispensing to act as a reminder to the person using it. The pharmacy had then completed a re-audit to check the actions had resulted in an increased uptake of the test, which it had. This demonstrated a commitment to quality improvement. The pharmacy monitored the levels of prescribing and medicine dispensing and had a good understanding of trends. For example, the team had accounted for the change in requests for gonorrhoea treatment pack according to pandemic lockdowns.

The pharmacy had a SOP relating to near miss errors and a near miss error record book. It had a SOP for team members to understand their roles in following duty of candour with errors. Team members completed several near miss error entries per month including some detail of learnings. The SI demonstrated the records made for two recent dispensing incidents. These were thoroughly recorded and investigated. Due to a delivery error to the incorrect address, the pharmacy had improved the checks made on the pre-printed postal labels. And the dispenser was observed following the new process during the inspection. Team members discussed the learnings from errors together and agreed the most appropriate changes to make.

The pharmacy had a written procedure to manage complaints. Team members described how they resolved concerns within their competence and escalated any serious complaints to the pharmacist. People had the opportunity to provide feedback about the pharmacy by telephone and email. The pharmacy provided its contact details on the website. Team members spoke at length with people on the telephone to help them understand the pharmacy processes and when the person could expect their medication. The team had identified that most complaints resulted from late delivery of medicines or delayed diagnostic test results. The pharmacy put processes in place to minimise this. It tracked people's medicine deliveries through the courier's tracking system, making it easier to resolve concerns. The pharmacy had proactively arranged to receive some test results in addition to the designated healthcare professional. This meant the pharmacy made sure people received their results in a timely manner.

The pharmacy had up-to-date professional indemnity insurance. The pharmacy didn't supply any controlled drugs (CDs) and didn't have a CD register. It didn't supply any medicines obtained from

specials manufacturers. The pharmacy held electronic private prescription records. The pharmacy held an accurate RP record. The clinical governance SOP laid out the standards for record keeping for services to ensure the pharmacy provided safe and effective care. The pharmacy kept records of clinical interventions, prescribing rationale, and any further communication with prescribers. These were accessible in the person's records for the pharmacy team and prescribers to see. There were several records seen where the clinical intervention by the pharmacist resulted in an amendment to the person's request on the online consultation questionnaire. And the records showed appropriate advice given to these people. The pharmacy kept order cancellation records on a spreadsheet, with an appropriate level of data granulation in terms of the reason for the cancellation. It was easy to identify, retrieve and review orders that had been cancelled due to clinical interventions. And the pharmacy recorded what actions had been taken in terms of advice and patient safety netting.

The pharmacy had considered the General Data Protection Regulation (GDPR) in its processes and had a confidentiality policy updated after 2018. People logged into a secure message centre with a unique password to access their test results. People could request an open email, and this was agreed with the person before sending. The pharmacy had a SOP for confidentiality and team members knew the importance of keeping people's private information secure. The pharmacy displayed its privacy policy on its website. It separated confidential waste from general waste, and this was shredded using an appropriately robust shredder. The SI had completed CPPE level 2 safeguarding and was aware of their responsibilities to protect vulnerable people. The pharmacy held records indicating that the prescribers from the online prescribing service had completed safeguarding to level 3. The pharmacy had a SOP relating to safeguarding people. Team members described conversations with vulnerable people that would alert them to refer queries to the RP. The pharmacy did not document details of the safeguarding risk in their risk assessment documents. Team members had a good understanding of the potential safeguarding issues with the supply of some medicines to people using their online prescribing service.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably experienced and qualified team members to safely provide its services. It supports team members to complete directed training relevant to people's health needs. The pharmacist has specialist knowledge and uses it to support team members' learning. Team members often suggest improvements to the ways of working. And they feel comfortable to raise concerns if they need to.

Inspector's evidence

On the day of the inspection, two qualified dispensers supported the RP, who was also the SI. On three days out of the five working days one dispenser supported the RP. On the other days there were two dispensers. This was organised according to the workload. During the inspection a regular locum pharmacist started a shift and her role included checking the prescriptions and supporting the end-to-end dispensing process. She had completed learning associated with the conditions and medicines supplied by the pharmacy. Team members were seen working well together and managing the workload.

The pharmacy provided a training plan for team members and it was relevant to the medicines and services provided. One dispenser's training record showed she had completed several modules provided by BASHH and related to sexual health. A large proportion of the services provided included providing sexual health diagnostic test kits and treatments. On a telephone call the dispenser confidently provided accurate information on when to test. The SI supported the team members in keeping their knowledge and skills up to date. The SI demonstrated specialist and up-to-date knowledge on the conditions and treatments the pharmacy provided. The pharmacy held a training matrix for the pharmacist and the online prescribers. This indicated their learning relevant to the services provided. This also included training on safeguarding, information governance, and whistleblowing.

The pharmacy held discussions on the days when all team members worked. These were not formal, recorded meetings but did allow an open and honest discussion about services and any errors made. These discussions allowed team members to be involved in decisions about ways of working and to learn from errors. The team members had either not had a formal appraisal or had not had one for a long time. Team members described how approachable the managers were and also how they felt able to raise concerns with the regular locum pharmacist if necessary. The pharmacy didn't set any targets for services.

Principle 3 - Premises Standards not all met

Summary findings

People access the pharmacy's services through its website. And this includes for an online prescribing service. The website provides information relevant to the conditions it offers treatment for. But allows the person to complete the selection of a medicine before completing a consultation for their condition. This is not in line with GPhC guidance. The pharmacy premises are clean, hygienic, and well maintained. And provide a suitable environment for the services provided.

Inspector's evidence

People did not access the pharmacy premises directly. The pharmacy was on the first floor of an office building. It was clean, modern, well-maintained, and hygienic. The pharmacy had an intercom system to restrict access to the office building. There was a lift and stairs up the pharmacy premises.

The pharmacy offered private services through its website. The website was professionally laid out with relevant information about the conditions and their treatment. It provided the pharmacy contact details and details about the SI and prescribers. But the website advertised and allowed the selection of a medicine and the quantity prior to the start of a consultation. And so, the treatment decisions appeared person-led rather than prescriber-led. The website indicated that it was the prescriber's decision on whether the treatment was suitable. And there were examples seen of order cancellations on people's pharmacy records following the prescriber's decisions. But the website layout does not meet GPhC Guidance for registered pharmacies providing pharmacy services at a distance. In addition, people could change their questionnaire answers and resubmit. These changes were not recorded on the system. This meant the pharmacy team and prescriber did not have this information to use as part of their professional decision making. It was discussed that this would be useful particularly in weight management treatment to ensure appropriate prescribing and supply.

The lighting in the pharmacy was bright, and the pharmacy had heating and air conditioning to regulate temperature. The pharmacy had enough bench and storage space for the workload. The medicine shelves were tidy, and medicines were clearly separated, some in baskets. The team kept benches mainly clear from clutter. And it kept floors and aisle ways clear to avoid slips and trip hazards. The team members had access to staff and toilet facilities with hot and cold running water. There was no separate sink in the pharmacy area, but the pharmacy did not use any water for medicines preparation.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has suitable safeguard checks in place to help manage and deliver its services safely. And the team completes clinical audits to assess any areas for improvement. People easily access the pharmacy's services and speak with knowledgeable team members about their medicines. The pharmacy mostly manages and stores its medicines appropriately.

Inspector's evidence

People contacted the pharmacy by email and telephone and accessed its private services by completing a consultation form on its website. The prescribers had the pharmacy's contact details and worked closely with the pharmacy. Once a consultation form was received the pharmacy contacted people for additional information when required. This was recorded on the person's pharmacy record. The pharmacy used a CQC registered diagnostic laboratory for test results, and it was open 365 days a year. The pharmacy securely accessed urgent test results outside the opening hours of the pharmacy and informed the person of the result. The pharmacy used a courier to deliver medicines and diagnostic tests to people's homes and used tracked delivery to provide an audit trail. The pharmacy had the facility to re-consign deliveries if there were issues with delayed or non-deliveries. The pharmacy placed medicines ready for delivery in sacks, separate from any prescriptions still being prepared. The pharmacy had robust processes to ensure people who had paid for urgent deliveries received them as planned. This included medicines for emergency hormonal contraception. A dispenser described how they signposted people to local healthcare services if they couldn't guarantee delivery for the person to take their medicines according to clinical guidelines.

The pharmacy had separate areas for administration of prescription requests, labelling, dispensing, and checking prescriptions. There was a postal labelling machine on the dispensing bench. The dispensers printed these labels, which were specific to the courier used, at the start of the dispensing process. This allowed the dispensers and the pharmacist to check the label for accuracy against the prescription during the dispensing process. Following a recent error, the dispenser and pharmacist now initialled the prescription to confirm the name and address on the postal label matched the prescription. The dispenser explained how signing highlighted the importance of a thorough check. The pharmacy used baskets to help keep different people's prescriptions and medicines separate.

Once a person accessed the online prescribing service and a prescriber authorised a prescription it became available to download and dispense at the pharmacy. The team could not download or print any cancelled prescriptions. This ensured only authorised supplies were made. The system highlighted any possible duplicate accounts identified by email addresses, date of birth and name and addresses. This meant the pharmacy was able to follow up on any potential duplicate requests. The pharmacy team contacted the person when a repeat request was made to ask the reason. The pharmacy had records of requests that had been cancelled following these communications. The pharmacy dispensed a range of agreed medicines, for a limited range of conditions from prescriptions received from the online prescribing service. This included for weight loss and erectile dysfunction. The pharmacy supplied a range of diagnostic test kits for example, Group B Streptococcus (GBS) testing kit and several sexually transmitted infection (STI) test kits. The pharmacy worked closely with other healthcare professionals, for example, with midwives for GBS testing. They signposted people following the receipt of their test results to ensure they were supported and got additional information about their treatment. For GBS

this included signposting to the Group B Streptococcus Support website gbbs.org.uk and their support helpline. The pharmacy had started to provide a range of COVID-19 tests for people using a UKAS registered laboratory.

The pharmacy had some safeguard checks in place to monitor prescribing and dispensing. The pharmacy had checked their antibiotic prescribing for cystitis was within current guidelines. They found a higher level of trimethoprim prescribed rather than the expected nitrofurantoin. This was even though the information on its website informed people nitrofurantoin was first line treatment. The pharmacy reviewed the pricing of the medicines as this was considered a factor in selection. People selected the medicine from the website prior to the consultation, rather than the prescriber choosing the medicine. And the prices of the two antibiotics was displayed on the website. The pharmacy asked people for their GP's details during the consultation questionnaire. The team had previously contacted people's GPs by fax following an online consultation. This had been reviewed since GDPR and they now provided a downloadable copy of the letter to people so they could inform their GP of treatment. This meant the emphasis was on the person to inform the GP rather than the prescriber or pharmacy. The letter the pharmacy used informed the prescriber of details of treatment, date of supply and contact details for the pharmacy.

The pharmacy provided treatments for weight loss and the team supported people with advice and signposting. The online consultation questionnaire required people to input height and weight and recorded the person's body mass index (BMI). This was obtained for each supply and recorded directly on to the pharmacy records. For Saxenda, the pharmacy team showed the checks made to ensure the person's BMI was within the licensed range for treatment. If it was not, then the medicine was not supplied. But the prescriber and pharmacy had missed an incorrect height on a person's records that would have meant the BMI was not suitable for treatment. The pharmacy completed some ongoing checks with people using Saxenda. But did not check some clinical details, for example for people who had received several Saxenda pens at once, checks were not made to ensure they had reached the optimum dose for treatment. The pharmacy kept records of people only requesting one Saxenda pen but did not proactively follow up to understand why they had not continued treatment up to the optimum treatment dose. The pharmacy had plans to expand its weight management service with more advice and support. The pharmacy team had a good understanding about trends in requests for weight management medicines as this was monitored regularly.

The pharmacy obtained its medicines and diagnostic test kits from appropriate sources. It stored medicines requiring cold storage in a medical fridge and kept a daily record of fridge temperatures. The temperature in the fridge was seen to be within the correct range. The pharmacy used cold packs to deliver medicines requiring cold storage and stored these tidily in separate fridges. The pharmacy had a date checking SOP and the team regularly checked the medicine expiry dates. The dispenser was seen checking the expiry date of medicines she was dispensing. No out-of-date medicines were found from a sample checked. The pharmacy transferred a couple of high-volume dispensed medicines into other packaging to help dispense them more efficiently. This was either into white skillets or other manufacturer's packs. The team members only transferred medicines with the same batch number and expiry and included a patient information leaflet (PIL). For the manufacturer's pack the quantity was added to the pack. But for the medicines transferred to skillets the team didn't add the medicine name, form, strength, and quantity to the box and so it did not meet requirements. A dispenser completed the transfer with no accuracy check by the pharmacist. The dispenser and pharmacist checked the quantity and contents of the packaging when dispensing and checking the medicines, but the medicines stored in baskets on the shelves had not been checked. The pharmacy had medicinal waste bins available for returned medication and out-of-date medicines. These were collected by a private waste contractor. The pharmacy received emails of medicine recalls and safety alerts, but it was unclear if these were

from the MHRA. The team confirmed to date there had been no recalls or safety alerts for the medicines that the pharmacy stocked.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has suitable equipment for the services it provides. And the pharmacy uses its equipment in ways that protect people's private information.

Inspector's evidence

The pharmacy had relevant reference resources and access to the internet for up-to-date information. The pharmacy had password-protected computers. The pharmacy restricted access to the pharmacy so non-authorised people couldn't view confidential information. The pharmacy stored people's medicines awaiting delivery securely in the pharmacy until the courier picked them up. The pharmacy had suitably sized medical fridges and stored the cool packs they used in separate fridges. It had discreet packaging suitable for delivery by the courier. The manufacturer had confirmed that the packaging and cool packs used for delivery of fridge lines kept the medicine within the required range for 72 hours. The pharmacy had checked this before starting to use the packaging. The pharmacy had the sharp bins it needed for the weight management service.

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.