

# 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:** 20/10/2022

## Pharmacy context

The pharmacy is in an office building close to the town centre of Wilmslow in Cheshire. It works with a prescribing service providing online private services via its website [www.webmed.co.uk](http://www.webmed.co.uk). The prescribing service is registered with the Care Quality Commission (CQC). The pharmacy offers a range of diagnostic testing kits and treatments for sexually transmitted infections (STIs). This includes Group B Streptococcus (GBS) testing. The pharmacy provides other services, including a weight management programme and treatment for erectile dysfunction. People do not visit the pharmacy premises and so they receive their medicines and diagnostic tests as a delivery to their home.

## 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
<b>1. Governance</b>	Standards met	1.6	Good practice	The pharmacy keeps good records of decisions and interventions to show how it supplies medicines safely. Both the prescriber and pharmacy team members regularly use these records to help provide effective care for people accessing its services. The team keeps up-to-date records of requests it refuses. And this helps the pharmacy monitor the appropriateness of the supplies it makes.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy suitably identifies and manages the risks associated with its online services, and it works well with the prescriber. Its procedures are relevant and help team members to provide services safely. When team members make mistakes, they proactively make changes to their practice to reduce the risk of similar mistakes in the future. They keep good records of decisions regarding the supply of medicines and interventions. And they are good at using these records to help give effective care for people. Team members have the training and knowledge to help vulnerable people and they keep people's confidential information secure.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) relevant to its services, including clinical governance procedures for its private online prescribing service. The SOPs had version control and the date of last review was documented within the SOP. The SOPs were the same as the previous inspection, having been reviewed in March 2021. Team members, including the regular locum pharmacist, had read the SOPs in 2021 and they had signed to confirm this. Pharmacy team members were seen completing appropriate tasks for their roles and referring queries to the pharmacist when needed. The correct Responsible Pharmacist (RP) notice was displayed.

The online prescribing service was registered with the CQC and used a GMC registered prescriber. The superintendent pharmacist (SI) and prescriber worked well together to review services, treatments, and the content of the website. People accessed services through the pharmacy's website by completing an online consultation form and submitting it to the pharmacy. After an initial review by the pharmacist, the consultation form was submitted to the prescriber. The prescriber worked remotely, and the SI reported they had an encrypted log-in that no-one else could access. The pharmacy had written risk assessments (RA) for its services and medicines. The RA for Saxenda had been completed in 2019 and was agreed by both prescriber and SI. The RAs had not been reviewed since the previous inspection. A regular review of the RAs could help the pharmacy identify any changing risks. The clinical governance SOP 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 helped provide an anticipatory approach to risk identification and management. The SI and prescriber had assessed the possibility of increasing the scope of the weight management service. This included extending the range of medicines to include Mysimba and Ozempic. Due to the risk profile of Mysimba and the unlicensed use of Ozempic the decision had been made to not include these medicines in its weight management service. But these decisions had not been documented as part of the written risk assessments.

The pharmacy tracked the review dates of its policies and online consultation forms. Any changes were documented with who had agreed the update and why it was necessary. Several updates were attributed to changes in clinical guidance. 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 had previously completed clinical audits, but no formal audits had been completed since the last inspection. This means the pharmacy may miss ongoing opportunities to improve. The findings from a previous audit relating to the supply of gonorrhoea treatment packs had identified a low uptake of the completion of the free test of cure, which was an important part of the treatment. The changes to the pharmacy's processes seen at the last inspection to improve the uptake

of testing had been maintained, with a continued increase in uptake of testing. The pharmacy monitored the levels of prescribing and medicine dispensing and had a good understanding of trends. For example, they had seen an increase in females accessing its STI testing and treatment services. The pharmacy had gathered data relating to the number of people making changes to their height and weight before submitting the online consultation form when requesting weight loss treatment. For supplies of Saxenda, they had recorded when this had happened and of the actions taken. Approximately 1% of people completing the form changed their answers and, in all cases, this had been queried with the person. The majority of these people were refused treatment as not suitable.

The pharmacy had a SOP relating to near miss errors and used a near miss error record book, making several entries each month. Most entries included detail of learning from the errors. The SI and team members openly discussed near miss errors together. One team member described how she had recently changed how she completed the dispenser's check, following an error and discussion with the pharmacist. She felt annotating the prescription during dispensing had helped reduce errors. The pharmacy had a SOP for team members to understand their roles in following duty of candour with errors. The SI demonstrated a record and learning from a recent dispensing incident. The pharmacy had a written procedure to manage complaints. Team members described how they resolved any concerns within their competence and escalated any serious concerns to the pharmacist. The pharmacy identified that most concerns were associated with the delivery service and team members were seen clearly explaining to people on the telephone when people could expect their medicine. The pharmacy tracked deliveries through the courier's tracking system and kept people updated of any delays by email and telephone. People using the pharmacy's services had the opportunity to provide feedback by telephone and email. And the pharmacy provided its contact details on the website.

The pharmacy had up-to-date professional indemnity insurance. It didn't supply any controlled drugs (CDs) and didn't have a CD register. It didn't supply any medicines obtained from special manufacturers. The pharmacy held electronic private prescription records. The RP records seen were completed accurately. The clinical governance SOP described the standards for record keeping for services to help ensure the pharmacy provided safe and effective care. The pharmacy kept records of contact with people using the service, of clinical interventions, prescribing rationale, and any further communication with prescriber. These were accessible in the person's records for team members and the prescriber to see. The team demonstrated how the records were referred to following receipt of repeat requests and to resolve queries during dispensing. The examples seen showed relevant and detailed records with clear communication to the person and signposting, for example, when requests were refused. The pharmacy kept cancellation records on a spreadsheet, including the reason for the cancellation. It was easy to identify, retrieve and review requests that had been refused due to clinical interventions. And the pharmacy recorded what actions had been taken including any advice given.

The pharmacy considered the General Data Protection Regulation (GDPR) in its processes and had a confidentiality policy updated after 2018. It provided a variety of ways for people to receive communication and test results, including people logging 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 a robust shredder.

The pharmacy had a SOP relating to safeguarding people and one team member demonstrated the completion of level 1 safeguarding training. Team members described conversations with vulnerable people that would alert them to refer queries to the RP. The SI had completed CPPE level 2

safeguarding and had a good understanding of the risks of supplying medicines to vulnerable people using online services. The pharmacist contacted the person if they had concerns. The pharmacy had some inbuilt procedures to help protect potentially vulnerable people. This included having visibility of changes to the online questionnaire for weight loss and not supplying emergency hormonal contraception when the person completing the questionnaire was male. The pharmacy did not document details of the safeguarding risk in their risk assessment documents. This had been highlighted at the last inspection.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a small team with the necessary skills and qualifications to provide its services safely. Team members keep their knowledge up to date by completing training relevant to the services provided. The pharmacist has specialist knowledge and helps support team members with their learning. The team works well together to improve services and to help reduce risks of mistakes.

### Inspector's evidence

On the day of the inspection, the RP, who was the SI of the pharmacy, worked with two qualified dispensers. There was a further dispenser and a regular locum pharmacist, working one day a week. Staff cover was organised according to workload. Team members were seen working well together and managing the workload. The pharmacy had an instant messaging chat option on its website and team members had capacity to respond to messages immediately. Team members had completed training relevant to the pharmacy's services and medicines supplied. They had training certificates for several modules provided by BASHH relating to sexual health. A large proportion of the services provided included providing sexual health diagnostic test kits and treatments. During the inspection the dispensers confidently answered questions and provided advice. They referred to the pharmacist when they needed to. The SI supported 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. And specifically on a weight management medicine due for licencing in the UK early the next year.

Team members held discussions most days to ensure they were kept informed of changes. It also gave them the opportunity to raise ideas and to discuss any errors made. This allowed team members to be involved in decisions about ways of working and to learn from errors. Team members described the SI as approachable, and they felt able to raise concerns with her and the regular locum pharmacist if necessary. The pharmacy didn't set any targets for services.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided. They are clean, hygienic, and secure. The pharmacy's website is professional and easy for people to use. The way it is set up enables the pharmacy and its prescriber to make decisions about the suitability of its treatments.

### Inspector's evidence

People did not visit the pharmacy premises as it was closed to public access. They accessed the private services offered, through the pharmacy's website. The website had been amended since the last inspection. It was professionally laid out with relevant information about the conditions and their treatment. For weight loss, this included a video of how to use the Saxenda pen, and information on weight management. Pharmacy contact details and details about the SI and prescribers were available on the website. People completed a consultation form, relating to their condition or selected one of the test kits to purchase. They didn't select a medicine from the website, before completing the consultation form, and it was made clear it was the prescriber's decision to determine suitable treatment. The pharmacy had made changes so the prescriber and the pharmacy had visibility of people changing their answers on the form. The SI demonstrated how this information had been used as part of the prescribing decision to ensure supplies of Saxenda were appropriate.

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 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 and floor clear from clutter. 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

Overall, the pharmacy manages the delivery of its services safely. It contacts people, when necessary, to make sure it supplies medicines and testing kits appropriately. The pharmacy makes considered decisions on the medicines it supplies and provides useful information on its website to keep people informed. It gets its medicines and testing kits from suitable suppliers and stores and manages them as it should.

### Inspector's evidence

People accessed the pharmacy's private services by completing a consultation form on its website. They could also contact the pharmacy by telephone and email for queries and for support when completing the form. The pharmacy ascertained a person's preferred method of communication to respect their privacy. It provided medicines for a limited range of conditions. And it 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](https://gbbs.org.uk) and their support helpline. There was relevant and up-to-date information about conditions and treatments on the website, for example the cystitis treatment page had been reviewed on 28 April 2022. The pharmacy posted blogs relating to the treatments and services provided. For example, a blog relating to Saxenda, gave tips for managing the nausea that people may experience on starting treatment. Following on from the decision to only supply licenced medicines for weight loss, the pharmacy published a blog providing information relating to Wegovy, Saxenda and how Ozempic was unlicensed for weight loss.

The pharmacy used a recognised system to complete identity checks of people requesting treatment and this helped prevent people setting up duplicate accounts. It included checks on age, address etc. and any anomalies required a further driving licence or passport check. Following the receipt of online consultation forms and orders for test kits, the pharmacist reviewed them for suitability. People were contacted if there were any queries and for more information if necessary. This was documented on the person's records. The prescriber reviewed the consultation forms together with any additional information. The prescriber had visibility of any previous treatments and historic records. The pharmacy recorded any cancelled orders on a spreadsheet so the records could be accessed in case of queries or for audit purposes. The team demonstrated examples of the information recorded on the system following cancellation of orders and the communication sent to people to explain. 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.

Once the prescriber authorised a prescription, the pharmacy downloaded it and started the dispensing process. The pharmacy had separate areas for administration of prescription requests, labelling, dispensing, and checking. The team used baskets to help keep different people's prescriptions and medicines separate. There was a postal labelling machine on the dispensing bench and labels were printed at the start of the dispensing process. This allowed both team members and the pharmacist to check the label for accuracy against the prescription. The pharmacy used a recognised 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 track orders and re-consign deliveries if there were issues with delayed or non-deliveries. The pharmacy placed medicines ready for delivery in sacks. It had robust processes to ensure people who had paid for urgent deliveries received them as planned. The pharmacy used a CQC registered diagnostic laboratory for test results, and it was open 365 days a year. The team securely accessed test results and informed the person of the result. The pharmacy asked people for their GP's details as part of the consultation form and it provided a downloadable copy of a 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 pharmacy therefore didn't know when a person's GP had been informed. This included treatment for weight management, which requires ongoing monitoring. 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 form required people to input height and weight, and this then calculated 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 they made to ensure the person's BMI was within the licensed range for treatment. If it was not, the medicine was not supplied, and this was confirmed with a number of people's records seen. People received additional resources, such as a journal and a diary with their first supply to support them with their treatment. The pharmacy didn't have systems to independently check a person's BMI and relied on further email and telephone conversations to verify any queries on suitability of treatment. The pharmacy had not considered video consultations as part of this service. The pharmacy had a new weight management website in testing, which was planned to run alongside the existing website with a link. The site was visible through a test link as the team completed ongoing testing before going live. The website information had an emphasis on diet, wellness, and exercise advice, alongside the provision of weight loss medication. The pharmacy had employed a fitness coach, who had designed gentle exercises for people who were overweight or obese. It had also employed a wellness coach, who planned Saturday morning sessions for people to complement their treatment. Both their details were clearly displayed on the test website. The SI explained how monthly emails would form part of the weight management subscription service, checking in on how people's treatment was going and sharing advice, tips, and healthy recipes. This was part of the pharmacy's plans for ongoing monitoring of a person's treatment. There was a clear emphasis on helping people manage their weight to improve their health.

The pharmacy obtained its medicines and diagnostic test kits from recognised 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. The pharmacy had a date checking SOP and the team regularly checked the medicine expiry dates, but the date checking matrix was not kept up to date. 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 boxes 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 white boxes the team added the batch number and expiry but didn't add the name and details of the medicine in the box. The SI demonstrated her robust checking of these pre-packs during the dispensing process. The pharmacy had medicinal waste bins available for returned medication and out-of-date medicines, which were collected by a private waste contractor. The pharmacy received emails of medicine recalls and safety alerts. 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 the equipment and facilities it needs to provide its services. And it suitably uses its equipment to protect people's privacy.

### Inspector's evidence

The pharmacy had reference resources, relevant to its services and access to the internet for up-to-date information. It had the equipment it needed for its services. It had suitably sized medical fridges and stored the cool packs they used separately. 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 team used discreet, robust packaging suitable for delivery by the courier.

The pharmacy had password-protected computers and restricted access to the premises so unauthorised people couldn't view confidential information. The pharmacy stored people's medicines awaiting delivery securely in the pharmacy until the courier picked them up.

### 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.