General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmadocs UK Limited, Unit 1, 223 East India Dock Road, London, E14 0ED

Pharmacy reference: 9011198

Type of pharmacy: Internet

Date of inspection: 08/09/2023

Pharmacy context

This is a distance-selling pharmacy co-located with an optician business and on a busy main road. The pharmacy premises are closed to the public, and people access the pharmacy's services through its website, www.accessdoctor.co.uk. The pharmacy dispenses private prescriptions issued by pharmacist prescribers working for the pharmacy for a range of conditions including erectile dysfunction, hair loss and skin conditions. It does not provide NHS services.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages most of the risks associated with the provision of all its services Including its prescribing and dispensing services. It has documented procedures for team members to follow to help make sure people receive medicines suitable for them to take. And it monitors the safety and quality of its prescribing service by carrying out regular reviews. The pharmacy has procedures to learn from its mistakes. It keeps the records it needs to by law, to show that medicines are supplied safely and legally. The pharmacy keeps people's private information safely and its team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy's main activity was dispensing prescribed treatment accessed via its website www.accessdoctor.co.uk for a wide range of conditions. These included asthma, erectile dysfunction, urinary tract infections and skin conditions. The prescribing service was provided by a pharmacist independent prescriber (PIP) who was also the superintendent pharmacist (SI) for the pharmacy.

The pharmacy had risk assessments (RA's) for the services and products it issued private prescriptions for. A selection of these were seen by the inspectors. Service risk assessments were sufficiently detailed, reflecting a treatment overview of the condition, the need for additional information from people for the consultation and considerations for prescriber competency. The RA considered the risks associated with providing the service online, and detailed controls or measures in place to mitigate these risks. They were informed by UK national guidance such as the National Institute for Health and Care Excellence (NICE) and the Summary of Product Characteristics. This ensured a uniform approach to prescribing decisions. But there was no consideration around differences in local prescribing guidance in relation to antibiotics. And antibiotics for urinary-tract infections were among the most prescribed items by the PIP. The SI agreed to review this and amend the risk assessment to reflect local treatment guidance. And following the inspection he confirmed that antibiotics were now only issued for three days treatment in line with guidance. RAs stated maximum quantities and frequencies for each medicine to avoid inappropriate treatment. The clinical team reviewed RAs annually. And reviewed earlier if prompted by a change in service, such as the introduction of a new medicine or on receipt of an alert from the MHRA. Some products reviewed by the clinical team were no longer prescribed following risk assessment. For example, they had decided to stop providing injectable weight loss medicines on prescription as they had identified that they would not be able to carry out effective monitoring when providing the service at a distance. But the pharmacy still listed some treatments on their website despite not providing them on prescription. They were marked as "out of stock" on the website. There was no evidence that these products had been prescribed recently. The SI gave assurances that these would be reviewed and removed from the website following the inspection.

The pharmacy had an identity checking process and used recognised external software to confirm the identity of people. These checks included the person's name, address (billing and delivery), phone number and email where given. If the software identified a failure in the information submitted, the person would be required to submit further information including a photo of the person with their ID for the pharmacy to verify. Team members were then able to identify those entering false or fraudulent details and ensure confidence in the person's details and identity.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its traditional pharmacy processes. Members of the team present said they had read the SOPs but they had not signed them to provide evidence that they had done so. The pharmacy was closed during the inspection, so no prescriptions were being dispensed. But the pharmacist showed how they would dispense a prescription, and this matched the process in the SOP.

The pharmacy had processes to review the quality of the prescribing service it provided. The clinical team consisted of the SI, the regular RP who was also a qualified doctor, and the medical director who was a GMC-registered doctor. The team had clinical meetings monthly, and discussions included consideration of mandatory GP notification for higher-risk medicines. This included medicines used to treat asthma and urinary tract infections. The medical director reviewed a sample of the PIPs prescribing consultations to determine whether the decisions were safe and appropriate. They discussed feedback on the outcome of the audit with the PIP. But this was for a relatively small sample of prescriptions in comparison to the consultations carried out.

The pharmacy used proprietary software for managing the prescription process. The prescriber was able to demonstrate how they reviewed a consultation on the platform. They accessed a list of medication requests, and reviewed the information submitted by a person online. They approved the prescriptions once they were satisfied that it was safe and appropriate. Or they contacted people if they needed to discuss the request or needed further information. When a prescription was generated, the system logged the name of the prescriber, and it was date and time stamped to provide a complete audit trail. The software clearly identified who was responsible for reviewing the request and issuing the prescription. The prescriber added notes of any advice given on a consultation notes section on the system. But additional consultation notes were usually only completed when a prescription was rejected. The prescriber did not always put a comprehensive explanation for their reason to issue a prescription and this might make it more difficult for a future prescriber to refer to this decision.

The PIP demonstrated they were appropriately reviewing and refusing supplies of medication that were not suitable for people. And people who had ordered certain medicines frequently were highlighted so that no further supplies were made. Examples of consultations were seen where the pharmacist had asked for more medical information. If people did not provide further information or contact the pharmacy, then the order was rejected. The pharmacy documented any medication requests that were rejected onto people's records to inform future prescribing decisions. The clinical check was carried out by the RP. This separated the prescribing and checking process which provided an extra check of clinical appropriateness. The RP could view details provided by people in the prescribing consultation and any prescriber notes when required as part of the clinical check. And the RP contacted the PIP if they had a query with the prescription or required further information. The SI carried out regular audits on prescribing consultations. The medical director peer-reviewed a selection of consultations by the PIP and then provided general feedback and any learning points. This allowed the pharmacy to ensure a consistent and supportive approach to prescribing.

The pharmacy had a process for recording dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). The operations manager said that that there had not been any dispensing errors but could explain the process that they would follow if one took place. Near misses were discussed with the member of staff at the time and then recorded in the near miss log. Learning points and action taken recorded in the near miss log were limited. The pharmacy had weekly team meetings in which near misses were discussed. The operations manager explained how the pharmacy had separated stock and put-up stickers to remind staff that the medicine was a look-alike, sound-alike (LASA) medicine and to take extra care.

The pharmacy maintained appropriate records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP) log, the controlled drug (CD) registers and the private prescription record. The pharmacy had built its own PMR system which meant that it was not always easy to find the required records. But the team was able to do so. The system did not record clinical interventions made by pharmacy team members and it did not provide information about interactions or contraindications. Team members could review a history of all medication dispensed by the pharmacy. The pharmacist or team members did not routinely review consultation notes made by the prescriber. But they could access a non-modifiable record of these on a separate system if required. The pharmacy was no longer supplying controlled drugs. A random check of the recorded running balance of a CD matched the actual stock. Professional indemnity insurance was in place.

There was a complaints procedure in place. The pharmacy published how to make a complaint on its website. The operations manager explained that most of the complaints were about deliveries. The pharmacy had an information governance policy. Computer terminals were positioned so that they could not be seen by people visiting the pharmacy. Access to the electronic patient medication record (PMR) was password protected. Confidential waste was shredded securely. The pharmacist was aware of safeguarding requirements and the team had completed appropriate training. The PIP only prescribed for people over the age of eighteen years old. And they used a recognised identification verification system to check people's details were entered correctly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members manage the workload within the pharmacy, keeping up to date with both dispensing and clinical governance. They can raise concerns if needed. Team members do training relevant to their roles. But the pharmacy does not always register them on accredited courses in a timely way.

Inspector's evidence

The pharmacy had two dispensers. Neither had been registered on a recognised dispensing assistant's course. The operations manager explained that they had decided that a standard course was not appropriate for an online pharmacy service. The two dispensers had completed a range of training including about safeguarding. The superintendent subsequently provided evidence that both had been registered on a recognised course.

The pharmacy had enough staff to manage its workload. The pharmacy team had regular team meetings where any concerns or issues could be raised. The RP explained that if they had any concerns about prescriptions issued by the PIP, they communicated these back to the prescriber. The pharmacy used a small pool of locum pharmacists to cover when the regular RP was off. It had a guide for locum pharmacists which included training on the use of the patient medication record, requirements for continual professional development and indemnity cover. And it provided signposting to the SOPs which were required to be read and accepted before assuming the role of RP.

The PIP explained they completed ongoing revalidation in line with the requirements of their professional body. They maintained a prescribing competency record which was used as part of the PIP's regular review with the medical director. It provided a record of the PIP's experience, training, and limitations of practice. The PIP also worked part time in a hospital role which gave them further clinical experience. They explained that there was a process to discuss prescribing decisions with the medical director when required. The PIP was employed directly by the pharmacy based on the time they worked and were not incentivised to provide a prescription.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's website provides relevant information to people using its services. The pharmacy keeps its premises safe, secure, and appropriately maintained.

Inspector's evidence

People accessed treatment through the pharmacy’s website. The website contained details about who owned the pharmacy, its location and contact details. The website was laid out in such a way that people had to complete the consultation before indicating which prescription-only medicine (POM) they would prefer.

The pharmacy was in the basement of an optician. There was no public access to the pharmacy. The dispensary was an adequate size for the services provided. There was suitable heating and lighting, and hot and cold running water was available. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy has sufficient safeguards to help ensure people receive medicines that are suitable for them to take. And it makes its services accessible to people through its website. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy was not open to the public. Its services were provided through its website. The pharmacy delivered all its medicines to people. It only delivered to addresses in the UK, it did not deliver to people who lived outside the UK. Prescribing consultations were undertaken via the company's website. The consultation was questionnaire based and avoided providing a negative response to any answered questions. This prevented people changing their answer to a question in order to obtain a medication that may not be suitable for them.

When people submitted a medical questionnaire for treatment using a POM, the answers appeared on the PIP's consultation system with a green, amber, or red rating for the PIP to review. If an answer was rated amber or red, the PIP had to consider the answer and was prompted to make an entry as to the action taken. The PIP recorded consultation notes when further information had been requested from people, or if the PIP had provided advice. But they did not record counselling notes for every prescription issued. There was evidence that the PIP signposted people back to their own GP when it was not suitable to prescribe medication. And provided testing kits to confirm the presence of an infection before prescribing treatment when required.

The pharmacy only provided treatment for certain conditions such as asthma if people agreed to allow the pharmacy to inform their usual prescriber of the supply. People were also asked questions about how well their asthma symptoms were controlled and when they last had a review by their GP. If people's answers suggested their asthma was poorly controlled, they would not be prescribed an inhaler and instead told to have a review with their own GP. The pharmacy did not have access to Summary Care Records. But it asked people to submit proof of medication being prescribed by their regular GP through submission of a digital copy of their repeat prescription, other repeat medication documentation, or photos of previous labelled prescriptions. And the pharmacy had a limitation of six inhalers for one person in a twelve-month period. This helped to ensure people did not order too many inhalers and could be monitored and reviewed appropriately by the PIP or the person's own GP. When the prescriber issued a prescription, the software had pre-defined doses for each medication. These were created in-line with each product's risk assessment.

The pharmacy dispensed private prescriptions which were generated electronically using the pharmacy's own software. Each prescription was processed by a dispenser, who generated a label for the products requested. The labels created included recommended warnings for use. These warnings were reviewed in line with service and product risk assessments. A copy of the prescription was printed and passed to the pharmacist for a clinical check. The PMR system did not provide an automated check of interactions between medications.

There was a range of information and advice on the pharmacy's website about the medicines that they provided. The responsible pharmacist said that he did not routinely contact people to give them advice about the medicines that they were being supplied. He said that he would consider how he could improve this part of the service.

Medicines were delivered by Royal Mail. The pharmacy was not supplying any medicines that required cold storage. Packages could be tracked, and the person was contacted if there was an issue with the delivery. People were asked to wait five days if their medicine did not arrive on time, before another supply was made. Medicines were stored on shelves in their original containers. The pharmacy team had a process for date checking medicines. A check of a small number of medicines did not find any that were out of date. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacist explained the process for managing drug alerts which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. Team members had access to up-to-date electronic reference resources and internet access allowing access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. Team members used passwords to access computers and did not leave them unattended unless they were locked. A shredder was available to destroy confidential information. The pharmacy's portable electronic appliances looked to be in a reasonable condition.

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.