General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: MSAGYA LTD, 4th Floor, Unit 4N, Moss Industrial Estate, Woodbine Street East, Rochdale, Greater Manchester, OL16 5LB

Pharmacy reference: 9011234

Type of pharmacy: Internet / distance selling

Date of inspection: 30/10/2019

Pharmacy context

This is a distance-selling pharmacy situated in a multi-storey warehouse. Its sole service is selling non-prescription medicines to UK residents via its website www.withaid.com, and its webpages listed as 247ukchemist and Swiftcare on the e-commerce retailer sites eBay and Amazon.

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’s working practices generally support safe and secure medicines supply. The pharmacy addresses its mistakes and acts to prevent them from happening again. It protects people’s private information. And the pharmacist understands how they should protect vulnerable people. But not all of its working procedures are written down, so staff might not always work effectively.

Inspector's evidence

The responsible pharmacist (RP), who was also the superintendent and resident pharmacist, demonstrated the pharmacy’s systems for making sure it supplied medicines both safely and securely. The pharmacy had written procedures for most aspects of the RP regulations. The superintendent said that the pharmacy had a procedure for ordering medication in a safe and effective manner. It had written procedures for arrangements during the absence of the RP, but it did not make clear what the staff could not do in the RP’s absence. So, staff may not be completely clear about all the pharmacy’s working practices.

Team members involved in the assembly and checking processes initialled the products selected for shipping and destination address labels, which helped to clarify who was responsible for each medication they had supplied and assisted with investigating and managing mistakes. The pharmacy team discussed and recorded mistakes it identified when preparing medicines for dispatch and it addressed each of these mistakes separately. However, staff usually did not record enough detail about the reason why they thought they had made each mistake, and they did not periodically review these records. So, could miss identifying patterns and additional opportunities to learn and mitigate risks in the medicine picking and shipping processes.

The pharmacy received positive feedback from people on customer service related issues such as supplying medicines correctly, in a timely manner, securely and undamaged. However, people were not asked for their thoughts on the quality of the healthcare element of the service including the pharmacy's recommendations, advice and information, so a representative view of its customers in these areas was unknown. People could make a complaint about the pharmacy’s service via the e-commerce platforms and its own website, and the pharmacy had written procedures for handling complaints.

The pharmacy had indemnity insurance cover that the superintendent pharmacist said was designed specifically for the service provided. The RP displayed their RP notice, and the pharmacy maintained the records required by law for the RP.

All the team members had signed to declare they had read the pharmacy's policies on keeping people’s information confidential. The pharmacy’s privacy notice was accessible via all three online platforms. The team mainly collected people’s information online via the e-commerce service provider’s messaging systems, which the superintendent said were General Data Protection Regulation (GDPR) compliant. The pharmacy also collected people’s information if they preferred to register directly with it via its own website and when they communicated using the pharmacy’s email system, which the

superintendent believed was GDPR compliant. People's medication requests automatically generated a shipping order on the pharmacy's external courier's web portal, which included their name, addresses and requested medication. The superintendent said that he understood that the courier's data collection system complied with GDPR, and they retained this information for one year only.

On the rare occasion that people telephoned the pharmacy it was usually to enquire about the progress of their medicine shipping status. The superintendent said that staff would ask people information security questions such as their address and shipping order reference before proceeding to handle their query, to make sure they were speaking to the right person. They also said that the pharmacy had covered this in its data handling policy, which staff had read.

The superintendent pharmacist, who had level two safeguarding accreditation was always directly involved in screening each medicine request. They provided examples of individuals who they suspected were attempting to repeatedly purchase medicines liable to abuse and informed each of them that the pharmacy was unable to sell the medication. However, they did not sign-post these people to another appropriate healthcare professional.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe and effective services. Staff have access to relevant training and the pharmacist supervises all medicines sales to make sure they are appropriate.

Inspector's evidence

The superintendent worked as the sole RP. The pharmacy had one other team member who picked and packed medicines supplies that the pharmacist had authorised. A staff member, who maintained the information technology aspects of the pharmacy's services, was the only other team member and they did not have any direct role in supplying medicines. The pharmacy had enough staff to comfortably manage the workload. Most medicines were ready for dispatch to people by 3pm on the same day of the request. The few remaining requests tended to be those that the superintendent had to query with people before they could proceed. The pharmacy did not have any incentives or targets for the service it provided.

The superintendent recalled identifying patients who they suspected could be inappropriately using medicines liable to abuse. They took appropriate action by refusing to sell the medication. The medicines picker, who started working in the pharmacy around a year ago, had started a medicines counter assistant (MCA) course in March 2019 but had only completed one module. Thid was not a major issue as they were not directly involved in querying or advising people about their medicine requests.

The superintendent explained that the pharmacy could feedback to its external courier any delivery service-related issues. However, the pharmacy did not have a formal arrangement with the courier to regularly review its service quality, so opportunities to improve the service could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s service, and it provides a professional environment for healthcare services.

Inspector's evidence

The pharmacy was situated in a large warehouse unit. Its office, storage and medicine packing areas were suitably maintained and it was professional in appearance: The open-plan packing area provided enough space for the volume and nature of the pharmacy's service. A consultation room was unnecessary because people did not visit the premises. The level of cleanliness was appropriate for the service provided. And staff could secure the premises to prevent unauthorised access.

The pharmacy’s address and contact telephone number were suitably displayed on the pharmacy’s website. However, other key pieces of information were not prominently displayed. For example, the owner’s identity could only be established via a link that did not make clear that it was for this purpose. The superintendent’s identity was not easy to verify on the pharmacy's website and the pharmacy’s email address was not displayed anywhere on it. So people may not be able to easily access this information if needed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy suitably manages its services to make sure it supplies medicines safely and efficiently. It gets medicines from licensed suppliers and it stores them appropriately, so they are suitable for use.

Inspector's evidence

The pharmacy's core operating hours were from 9am to 3pm Monday to Friday and Saturday 10am to 12 noon. People could place medicine requests at any time via the three online platforms, and the pharmacy completed most requests on the day it received them. The pharmacy had registered its website with the Medicines and Healthcare products Regulatory Agency (MHRA) to sell non-prescription medicines. It was also registered with the MHRA to sell General Sales List (GSL) and pharmacy (P) only medicines on eBay, and GSLs only on Amazon.

The superintendent explained that medicines requests came via the two e-commerce platforms, on which no opiates were offered for sale. The pharmacy received very few medication requests via its own website, and only a minimal number of these requests were for opiates or other medicines liable to abuse.

Medication requests from the e-commerce platforms and pharmacy's website were compiled in data collected on the pharmacy's external courier's web portal, which the pharmacy routinely accessed. This information was cross-referenced against individual's purchase histories before any medication requests were authorised, which helped to identify any multiple requests from the same address. An automated system also identified any repeat medication requests from the same address that the pharmacy had authorised to supply via its website if people had registered with the pharmacy. However, people using the pharmacy's website had the option to not register, which meant identifying repeat medication requests was more difficult. Despite this, the superintendent explained that said the risk of these medicines being supplied was low as they could identify them before the medication was picked for shipping. And they gave several examples of occasions when they had refused sales or requested further information.

People selected medication from a list of them displayed on the e-commerce platforms. Each eBay medicine listing stated to read the terms and conditions of sale section. This included that the pharmacy could query people's orders, and to contact the pharmacy via the platform's online messaging system before proceeding with the purchase if they were unsure about how to use the medication.

An automated email asked people to confirm that they had read the medicine's product information leaflet, don't have any other medical conditions or were not taking any other medication, and will consult a registered healthcare professional if their condition doesn't improve or worsens. The pharmacy declined to sell the medication when it did not receive a response to these questions after it made three requests. These arrangements helped to make sure people only received medicines that were suitable for them. However, the email did not include a requirement for people to confirm who the medication was intended. And some of these questions were closed and leading in their nature, which had the potential to suggest how people should respond in order to obtain the medication. They did not clarify after how long to contact a healthcare professional if their condition didn't improve or worsened.

The important information section in each eBay medicine listing contained relevant details taken from the NHS website and NICE guidelines about when to contact their GP or NHS 111. The automated email reminded people to read the listing's important information section, but it did not always make clear where to find it in the listing.

GSL medications listed on Amazon each had a terms and conditions of sale section. However, the pharmacy did not use it to add any relevant additional information to the section, and it was difficult to find because there was no obvious signposting to its location. A messaging system on the platform was available, but the pharmacy did not use it to seek any information about medicines requests. So, there was a risk that people could be supplied medication that was not suitable or did not receive any additional information or advice when they purchased these medicines.

People were first presented with a list of conditions and ailments to select from if they used the pharmacy's website. Medications were listed under the selected ailment, and a basic initial set of questions were presented alongside each selected medication that people had to respond to proceed. These questions included confirming that the medication's product information leaflet had been read, the person who would use the medication, that they were an age appropriate for the medication and neither pregnant nor breastfeeding. People also had to describe their symptoms, how long they had them, and any medical conditions or other medication they were taking. The superintendent reviewed every response submitted with each medication request and checked any associated purchase history. They sought additional clarification about the request from the intended purchaser where necessary, and the pharmacy kept a record of these online conversations. So, the pharmacy had a system for checking whether each of these sales would be safe and appropriate. A terms of sale section on the website stated that the pharmacy may not supply a medication following a submitted order, and it will try to provide the reason for doing so.

The superintendent produced each destination address label when they had authorised the medication request. Another team member then referenced the medication order details when they selected the medication, packed it and applied the address label. The superintendent checked the order details against the medication and address label just before completing packing process. These systems helped to make sure each medication was shipped to the correct address. The pharmacy picked and packed a large number of authorised orders at the same time, but it did not use any type of container to separate them, which could increase risk of medication being delivered to the wrong destination.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. It did not offer refrigerated medicines for sale and records indicated that it monitored medicine stock expiry dates. The team also took appropriate action when it received alerts for medicines suspected of not being fit for purpose and kept confirmatory records.

The team packed medication to be delivered in robust packaging. The pharmacy handed all its parcelled medicines to an external courier, who immediately scanned each parcel into its system, which the pharmacy could access. This allowed the pharmacy to track the progress of each parcel all the way through to confirming their delivery, and people also had the option of this service. The superintendent said that they were consistently present when the courier collected the parcels, as required under the RP regulations. These systems cumulatively supported the safe and secure supply of medicines.

The pharmacy's website stated that the pharmacy would deliver medicines between three to five working days from agreeing to supply the medicine. The courier had agreed to deliver medicines between two to three days from receiving the medicine. The pharmacy received most of its medicine requests in the early morning and checked for any further requests throughout the day. It usually dispatched uncomplicated medicine requests within twenty-four hours of the requests. So, the

pharmacy delivered medicines promptly to people.

Medicines had rarely not arrived at the destination address and these medicines were sometimes returned to the pharmacy around three weeks later. Occasionally, the courier had confirmed the delivery when people said they had not received the medication. If these were a repeat supply or medication liable to abuse the pharmacy would issue a refund and not make any further supplies. Courier staff had also sometimes recorded that they had delivered medication on the scheduled delivery date, when it was not delivered until one day after this date. The courier had addressed this and the pharmacy advised people to expect their medication shortly after the scheduled delivery date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively, which it properly maintains. And it has the facilities to secure people's information.

Inspector's evidence

The pharmacy mainly communicated with patients via the e-commerce platform's messaging systems and its email service, which the superintendent said each encrypted any data sent between the pharmacy and people. The pharmacy's website also stated that it stored people's data on secure servers, and it encrypted people's payment details pharmacy using secure sockets layer (SSL) technology. This supported information security principles such as encrypting the data transmitted between the people and pharmacy. And it ensured that the pharmacy received all the data that people submitted was that received. The RP could also speak to patients directly via the telephone. Members of the public did not visit the pharmacy, so it was unlikely that unauthorised persons could see people's data at the pharmacy. Medication was packed in discrete packaging for shipping, which helped to avoid anyone suspecting medicines were contained within the parcel or identifying who it was for.

The superintendent had access to the latest versions of the BNF and cBNF online, and they accessed the NHS and electronic Medicines Compendium online for information. So, they could refer to the latest clinical and medicines information.

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.