General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: British Chemist and All Chemists, 381 Church Lane, London, NW9 8JB

Pharmacy reference: 9011271

Type of pharmacy: Internet / distance selling

Date of inspection: 22/05/2023

Pharmacy context

The pharmacy is in a parade of businesses in a mixed commercial and residential area. It provides some services at a distance and face to face. The pharmacy dispenses private prescriptions and provides health advice. Services listed on its website include blood tests, online prescribing and travel vaccinations. It sells some over-the-counter medicines from the pharmacy's premises and through its website. The pharmacy does not dispense NHS prescriptions or provide NHS services. This was a follow-up visit after completion of an action plan issued at the previous visit.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.1	Standard not met	The pharmacy does not identify and manage some of the key risks associated with providing services at a distance. For instance, the prescriber does not always satisfactorily verify people's identity or medical history, the prescribing policy does not detail the steps that should be undertaken in a consultation in sufficient detail or reflect clinical risks for each condition. The pharmacy supplies a significant volume of higher-risk pharmacy-only medication (P Meds) via its website with insufficient safeguards in place.
		1.2	Standard not met	The pharmacy does not conduct internal or external audits or receive peer review to monitor its services and help make sure services such as prescribing are provided safely.
		1.6	Standard not met	The prescriber does not always keep detailed records of clinical information for face-to-face or online consultations when initiating prescribing or to share with people's doctors. The prescriber does refuse some supplies of medicines but does not fully document the reasons.
2. Staff	Standards not all met	2.2	Standard not met	The prescriber is unable to demonstrate suitable scope of practice and competency to provide some clinical services such as prescribing specialist medicines.
		2.3	Standard not met	The pharmacist shows a lack of awareness and understanding on the importance of verifying identification for online requests for medication and the importance of independently verifying and recording clinical history.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website does display up-to-date information but people can select prescription only medicine prior to an appropriate consultation.
4. Services, including medicines	Standards not all met	4.2	Standard not met	Overall, the pharmacy does not have sufficient governance procedures in place ensuring that it provides safe and effective

Principle	Principle finding	Exception standard reference	Notable practice	Why
management				services such as identification checks, verifying clinical information and recording consultations before prescribing medicines and treatment.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not identify and manage some of the key risks associated with providing services at a distance. For instance, the prescriber does not always satisfactorily verify people's identity or medical history. The pharmacy has written instructions to help make sure services such as prescribing are provided safely but the prescriber does not always follow all the steps in the process. And the pharmacy's prescribing policy does not detail all the steps the prescriber should follow to help make sure they prescribe the most suitable treatment. The prescriber does not always keep detailed records of people's relevant clinical information or share it with their doctor or with other healthcare professionals. The pharmacy does have measures in place to help limit the quantity of higher risk medicines which can be ordered. The prescriber does refuse some supplies of medicines but does not fully document the reasons. The pharmacy protects people's private information.

Inspector's evidence

During the visit, the superintendent pharmacist (SI) worked alone. There was a very low volume of dispensing and as the SI worked unassisted in the pharmacy, he relied on spotting mistakes or near misses after a mental break. He had a paper-based near miss book but he did not routinely record his mistakes or what he could learn from them. So, he may not recognise trends in the type of mistakes he makes and take action to avoid similar mistakes happening again. The SI described the workflow when dispensing prescriptions. He set the assembled prescription aside, taking a mental break before completing clinical and final checks and finally bagging the medicines. The SI kept a small stock of medicines. If the SI had to check an interaction between medicines for the same person, he could gain consent from the patient and access their summary care record or refer to the British National Formulary (BNF). The outcome of interventions was recorded on the person's patient medication record (PMR).

The SI described the pharmacy's process for selling medicine to treat erectile dysfunction. He would ask the purchaser for a current blood pressure reading, age, if the purchaser had had this medicine before and what other medicines he took routinely. The SI had not refused any sales and only maintained records for medicines he had prescribed. The pharmacy supplied a high volume of higher-risk pharmacy-only medication (P-Meds) via its website (kaolin & morphine, Phenergan 25mg tablets) and it did not provide a risk assessment for this. The SI said he did limit the frequency with which people bought certain medicines known to be liable to misuse. But there were boxes on the floor in the pharmacy each containing a pack of a liquid medicine known to be misused and the SI confirmed they were to be sent to people who had purchased them from the website. This was evidenced by examination of around 16 packing slips for the kaolin and morphine seen during the visit. There were also multiple orders for packs of antihistamine tablets sold to help people sleep but also known to be misused. The pharmacy did not complete any identity checks for the medication requests it received online so it did not verify if the person's details were correct. The pharmacy limited the quantity of these medications supplied and had a minimum duration before they could be re-ordered but this could easily be mitigated by providing alternative names and addresses.

The SI provided a document outlining the conditions treated at the pharmacy, but it did not sufficiently or consistently detail the steps that should be undertaken in a consultation such as how to take a

suitable history, differential diagnosis, medical observations or examinations, exclusions from treatments, red flags and safety netting advice. The document listed symptoms associated with each condition and some red flags but did not meet the criteria for a suitable prescribing framework or policy. The SI did not provide an antimicrobial policy. Regarding requests for medicine to treat a specific condition, there was evidence that people had made repeated requests too soon after the last supply and been prescribed more before it was due.

The SI provided a standard operating procedure (SOP) for the prescribing service but upon inspecting the consultation records, it was clear that it was not routinely followed for face-to-face consultations. The process for consultations that had been completed via an online questionnaire was outlined with a record kept of the website and a cross reference in the patient's medication record (PMR) entry. The website included details on how to get in touch https://www.britishchemist.co.uk/contact-us/ and how to complain https://www.britishchemist.co.uk/complaints-procedure/

The SI explained that he had risk-assessed all procedures in April 2023 but not recently completed any risk assessments (RAs) for services available at the pharmacy. The RAs considered the issues of having the same pharmacist responsible for the prescribing process also being involved in final the clinical and accuracy checks. Breaks between the two processes were implemented. After the inspection, the SI provided a RA. The RA identified some risks and the subsequent risk measures the SI had considered. But it did not address many of the key risks associated with providing medication from a distance such as identity checks and independent verification of a person's medical history. The RA did not suitably identify the likelihood and impact of risk and was more a checklist of what to include in an RA than an RA itself. The RAs combined with the pharmacy's prescribing policies did not appropriately reflect clinical risks for each condition.

Following an audit, the SI had concluded that he would stop telling people to split higher strength tablets to treat erectile dysfunction. The SI did not routinely conduct internal or external audits of the pharmacy's prescribing service to check and monitor compliance with its own prescribing policies and risks. And he did not receive peer feedback on the quality of prescribing. The SI notified the person's usual doctor via email of the services delivered if that person had consented to letting their doctor know. The SI attached a copy of the answers submitted from the online questionnaires but did not provide the same level of detail for consultations completed face to face. The pharmacy also did not separate the functions of the prescriber pharmacist from the functions of the responsible pharmacist (RP). This meant that as the SI worked alone, he was the prescriber pharmacist and the pharmacist undertaking the final clinical and accuracy checks.

The pharmacy displayed a notice telling people who was the responsible pharmacist (RP) and maintained a record that told people who the RP was and when. The SI confirmed that he had made all the entries because he had never had a locum pharmacist. Since the pharmacy opened and until now he had been the only pharmacist with no help from anyone. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. At the time of the visit the pharmacy had not supplied any unlicensed medicinal products and there were no controlled drugs (CDs) in stock requiring records to be kept. The pharmacy kept a record of the private prescriptions it supplied in a register along with the physical copies of the private prescriptions it generated. The pharmacy kept a record of all patient consultations from its website and interventions on its own internal systems.

In a number of random checks, the SI did not sufficiently document the clinical rationale when initiating prescribing including differential diagnosis, the checking for red flags or any appropriate safety netting for face-to-face consultations. The SI did not document the process or evidence confirming that a person was on regular medication when he was prescribing medication for chronic conditions, face-to-

face or for online interactions. The SI did not request and document clinical monitoring information in any of the consultations examined. People visiting the country from abroad could easily obtain prescription only medication without independent verification that the medication was safe and suitable for them and had been prescribed by a legitimate physician abroad.

The pharmacy was registered with the Information Commissioner's Office. Displaying a notice to tell people how their personal information was gathered, used and shared by the pharmacy team was discussed. The pharmacy's computer system was password protected and backed up regularly. The pharmacy took payment via a protected site. Confidential wastepaper was disposed of securely. The SI had completed a level 2 safeguarding training course and knew what to do or who to make aware if he had concerns about the safety of a child or a vulnerable person. But the SI did not request identification for online interactions with people accessing the pharmacy's services. This may mean medicines could possibly be obtained by children which could potentially be a safeguarding issue. The SI was signposted to the NHS safeguarding App.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy is unable to demonstrate that its prescriber has a suitable level of competency required to provide some of its clinical services such as prescribing specialist medicines. These are usually prescribed by specialist prescribers and fall outside his scope of practice. And he does not benefit from the feedback of peer review to identify gaps in his skills and knowledge.

Inspector's evidence

The SI was the sole prescriber, dispenser, clinical and accuracy checker and he explained that he generally worked alone apart from a colleague who helped out part-time. The SI's initial scope of practice as an independent prescriber was in hypertension. He had later completed a two-day intensive course covering a number of conditions with a non-accredited private provider (https://www.mhrxltd.co.uk). The course gave an overview of the theory and physical examinations in the form of an objective structured clinical examination (OSCE) on day two of the course. The course did not include experiential learning under supervision with a senior clinician or observation of procedural skills in practice.

There was no ongoing submission of reflections to demonstrate competency or auditing practice. Along with the poor clinical governance procedures currently in place, this was insufficient to demonstrate competency in all the areas that the pharmacist was prescribing within. He did not maintain a portfolio of practice as he had expanded into other clinical areas. The SI did not have confirmation of competency from clinical peers in the form of suitable testimonials. And the SI's subsequent move into other clinical areas was not in line with the requirements set out in the RPS competency framework.

The SI had prescribed medication reserved for specialist medical prescribers at the request of people, mainly from abroad. This was outside the SI's self-declared scope of practice, and he had made insufficient independent checks on the validity of these requests. And did not keep appropriate records of consultation notes to determine the clinical suitability for these medications. The SI was able to demonstrate refusals of supplies for medication because the patient's request contained responses that would exclude them from treatment. But this was not always documented in the pharmacy's PMR system.

During the visit, the SI produced some evidence of emails being sent to a person's usual doctor to notify them of his supply of medication. But the correspondence was merely a statement of supply rather than sharing a consultation. The pharmacy's process did not make it mandatory to send letters to notify a person's doctor. This meant that if people declined consent, they would still be provided with medication. The SI demonstrated a lack of awareness and understanding of the importance of verifying people's identity for online requests for medication. He did not show professional judgement and understanding of importance of independently verifying and recording clinical history. The SI did not demonstrate an understanding and application of independently verifying the need to prescribe medication that is usually prescribed by specialists. So the SI did not seek assurances by contacting the primary physician. The pharmacy did not charge a separate fee for consultations so its income was contingent on the supply of medicines.

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

Summary findings

The pharmacy’s website allows people to choose some medicines before having a consultation with its prescriber. It displays up-to-date information so people can contact the pharmacy and leave feedback. The pharmacy's premises are clean, bright and secure. The design and layout of the pharmacy is generally suitable for its activities and the provision of healthcare. The pharmacy prevents unauthorised access to its premises when it is closed. So, it keeps its medicines and people's information safe.

Inspector's evidence

The website included details on how to get in touch https://www.britishchemist.co.uk/contact-us/ and how to complain https://www.britishchemist.co.uk/complaints-procedure/ The SI explained that the website capped the purchase quantity of some medicines liable to misuse. At the time of the inspection, people could start the consultation after selecting a medicine on the website rather than starting a consultation from the ‘condition’ so the website did not comply with the GPhC standards. The pharmacy had removed all “blockers” which previously highlighted to the people completing a consultation questionnaire online that a certain answer would stop the supply of a medication. The user now had to complete the consultation in full without being alerted to change responses to the questions.

The pharmacy did not have an automated door. And there was a slight step at its entrance, so it was not level with the outside pavement. The pharmacy’s premises were clean, bright and well ventilated. The workbenches and floors were cluttered with stock, some of which was being packed up to fulfil orders. The pharmacy had an appropriate clinical treatment room to undertake face-to-face services such as a phlebotomy service. But there was no method of documenting consultations or recording consultations in the consultation room.

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

Summary findings

Overall, the pharmacy does not have sufficiently effective governance procedures in place to ensure that it provides safe and effective services. The pharmacy does not conduct suitable identification checks of people requesting its services online. It does not independently verify clinical information that people provide. And it doesn't always share detailed information with people's usual doctor about the treatment it provides them with. The prescriber does not record face-to-face consultations in sufficient detail, leaving out key areas of the consultation. This is not in line with the pharmacy's written procedure. People with different needs can access the pharmacy and its services. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages them so it can be sure they are fit for purpose. The pharmacist knows what to do if any medicines or devices need to be returned to the suppliers but it does not keep records so it may not be able to show that it took the right steps to keep people safe.

Inspector's evidence

The majority of the people using the pharmacy's services were online customers. There was an 'Ask a Question' section on the website. The website had contact details and a chat function with patients. People could access face-to-face services if required and consultations were made online or were 'face-to-face' with the SI.

The pharmacy did not have an automated door but the SI tried to make sure people could access the pharmacy's services and there was a notice at the entrance inviting people to ring the doorbell to alert the SI. And there was a ramp with anti-slip strips leading from the retail area to the consultation room. The SI signposted people to a nearby pharmacy if a service was not available at this pharmacy.

The pharmacy did not have safeguards in place for supplying some categories of medicines. The SI did not provide an antimicrobial policy but multiple prescriptions had been dispensed for antibiotic treatment for urinary tract infections. Examination of prescription records showed that repeat medication had been requested and supplied too soon since the previous supply which should have alerted the prescriber. The SI had prescribed medication usually only prescribed by specialist medical prescribers. This had been at the request of people, mainly from abroad. It was outside the SI's self-declared scope of practice, and he had made insufficient independent checks on the validity of these requests.

The pharmacy did not conduct identification checks for people requesting its services online or independently verify clinical information provided by people. The SI did not always obtain the contact details of the regular prescriber, such as their GP, and consent to contact them about the prescription. As a result he was unable to share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP). The pharmacy did not make sufficient records of its face-to-face consultations, missing essential components of a consultation demonstrating that the SI did not follow the pharmacy's SOPs. This may make it difficult to determine if the correct clinical decision was made during the course of a consultation.

The pharmacy had not conducted any suitable internal audits to determine if it was practising safely and according to guidelines. There were no external audits from peers to monitor safety and quality. The SI worked alone with no defined access to clinical support or any suitable supervision. The pharmacy provided a phlebotomy or blood testing service, and blood samples were sent to reputable laboratories for analysis. The pharmacy had bins for sharps and clinical waste disposal for the phlebotomy service it delivered. The pharmacy used a trackable service which made its deliveries within 24 or 48 hours.

The SI used baskets to separate each person's prescriptions and medication. He took a mental break between dispensing and checking prescriptions. Interactions between medicines were checked and interventions were recorded on the PMR. The pharmacy kept a small stock of medicines obtained from recognised wholesalers. It kept most of its medicines and medical devices in their original manufacturer's packaging. The dispensary was not tidy and there were items on the floor. The SI checked the expiry dates of medicines and recorded when this was done. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The pharmacy had a contract for collection and disposal of waste medicines if and when required. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the SI described the actions they took and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The SI had access to up-to-date reference sources. The pharmacy had a refrigerator and data logger to store pharmaceutical stock requiring refrigeration. Confidential waste was disposed of appropriately. There was cleaning equipment, sharps bins with sufficient capacity and clinical waste disposal for the phlebotomy service it delivered. It had the necessary equipment provided by reputable providers for the service. The pharmacy had adrenaline injections to treat anaphylaxis.

The pharmacy restricted access to its computers and patient medication record system. And only authorised persons could use them when they put in their password. The SI described the anaphylaxis kit which included adrenaline injection devices and the location of the nearest defibrillator. Maintenance of the blood pressure monitor was discussed.

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.