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

Date of inspection: 23/04/2024

Pharmacy context

The pharmacy is in a mainly residential area in north west London. It provides most of its services online so people generally can't visit its premises. The pharmacy was previously inspected on 22 May 2023 and various shortcomings were identified, including inadequately managing the risks involved in providing its services, failing to monitor how safe those services were and having insufficient safeguards in place when prescribing some medicines. As a result, conditions were placed on the pharmacy's premises registration, protecting the public by preventing it from offering a prescribing service. In addition, a separate action was also taken against the owner and former superintendent pharmacist, resulting in him being suspended from the register and a new superintendent (SI) being appointed. This inspection was undertaken to follow up that previous inspection and verify the actions taken by the pharmacy to meet our standards. Its services are limited due to the conditions placed on the premises and the then superintendent pharmacist being suspended from the register.

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 not all met	1.1	Standard not met	The pharmacy does not adequately identify the risks involved in selling medicines online. It doesn’t keep its written instructions sufficiently up to date so there is a risk the pharmacy team may carry out tasks they are no longer allowed to. And it may not be clear who is responsible and accountable for the supply of medicines. People's private information may not be protected when it is shared to obtain medicines for diabetes which also cause weight loss. The pharmacy does not adequately consider the risk of people with diabetes being unable to obtain their medicines as a result of it not following, and actively circumventing, the patient safety alert designed to protect stocks of those medicines for the treatment of people with diabetes.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The website is misleading in places because some information is incorrect. The pharmacy doesn't keep its website sufficiently up to date so there is a risk people looking online won't know who is responsible for what the pharmacy does. And it may not be clear who is responsible and accountable for the supply of medicines.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy has inadequate stock management procedures in place, resulting in unusually high stock levels of high-risk medicines which it has not been able to satisfactorily explain.
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 adequately assess the risks involved in selling medicines online that may be abused. The pharmacy doesn't keep all its written instructions sufficiently up to date so they may lead its team members to carry out tasks they are no longer allowed to. It doesn't keep its website sufficiently up to date so people won't know who is responsible for what the pharmacy does online. The pharmacy does not exercise a duty of care to protect stocks of medicines for the treatment of diabetes but also cause weight loss. And this may lead to a shortage of these medicines.

Inspector's evidence

The pharmacy was providing very few services at the time of the visit due to conditions placed on the premises registration through enforcement action. In a separate action, the owner and former superintendent pharmacist (SI), was suspended from the register. A new SI has been appointed.

The pharmacy was closed at the beginning of the visit. It displayed notices saying the pharmacy was closed today but still available by phone and online with contact numbers. Wholesalers, Royal Mail and others were directed to call a mobile number. There were details to book on the website or scan a QR code. On calling one of the numbers at the front door, the owner, and former SI (FSI) arrived.

The pharmacy had standard operating procedures (SOPs). The FSI supplied an index list of the SOPs after the visit. They were pre-prepared templates which the FSI had approved in Aug 2023 and they were due a review in Aug 2025. These SOPs included procedures for dispensing, responsible pharmacist (RP), safeguarding, complaints and controlled drugs. The sale of medicines SOP covered over-the-counter and online sales. The FSI provided the phlebotomy service SOPs which covered best practice and infection control. This service was still offered by the pharmacy. The FSI explained that only one SOP had been amended to reflect the current status status of the pharmacy and its services at the time of the visit. It was called: Receipt and Storage of pharmacy items. The remaining SOPs were unchanged until a pharmacist was appointed to take over duties in the pharmacy. People could leave feedback about the pharmacy online and via a complaints procedure on the website although the GPhC details had not been updated. The website included a chat function for people to use.

The FSI sent an audit plan risk assessment for online sales (of potentially abusable medication such as Phenergan tablets) and an audit plan for over-the-counter (OTC) sales of Phenergan tablets in the UK. Both were dated 11 April 2024 and neither identified the pharmacy being risk assessed or where the audit took place. The FSI referred to working alone but the audit and the risk assessment both mentioned staff involved in online sales may lack knowledge or be trained to provide guidance to customers on the potential risks and appropriate use of Phenergan tablets. The proposed frequency of the audit was six-monthly. And it did refer to the pharmacy not selling online since November 2023.

There was a large number of tins of baby milk, pharmacy only 'P' medicines containing codeine 8mg combined with ibuprofen or paracetamol and packs of 56 Phenergan 25mg tablets. When the quantities of baby milk and 'P' medicines were highlighted, the FSI commented that he kept receiving the P medicines from a supplier although he had not ordered them. There was a pile of Alliance Healthcare

invoices and credit notes dated October 2023 to February 2024 but not yet filed. These invoices and a credit note were charged to Mojji LS Ltd which is the company that owns British Chemist and All Chemists. The invoices were for Ozempic, Glucophage SR 1000mg, Dretine, Wegovy and baby milk. The FSI said that the baby milk was supplied online as it was not a medicine but it was not clear why the pharmacy had ordered
Ozempic, Glucophage SR 1000mg, Dretine and Wegovy. And it was also unclear whether or not they had been supplied to people by the FSI in a way that was not in accordance with the premises conditions or the restrictions on the practice of the FSI.

The FSI explained that other vendors or other pharmacies sold items through the British Chemist and All Chemists' website. People may see some medicines such as acetazolamide on British Chemist and All Chemists' website showing it was for sale by British Chemist but hovering the mouse over the item prompted a message saying 'not currently trading until further notice' and a button saying 'not selling'. Other medicines were labelled as being sold by other pharmacies. The FSI said that people completed the consultation questionnaire on the British Chemist website but it was transferred to the associated pharmacy for assessment before the medicine was supplied. The FSI said that the other pharmacies were responsible for what they sold. They made checks for identification and inappropriate requests such as multiple orders.

On the website there was a section to complete for 'Franchise registration'. and the website stated in 'Becoming a customer' and 'Becoming a seller' that supplies may be made by another pharmacy. Under 'Terms & Conditions' there was information about people's data, their rights and sharing data. People's data may be shared with third parties to facilitate completion of the purchase. The GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet states: If you have an arrangement with, or contract out any part of your pharmacy service to a third party, you are still responsible for providing the pharmacy service safely and effectively. You should carry out 'due diligence' in selecting any contractors. So the FSI and the associated contractors may not be clear on individual accountability for parts of the services provided to people. Documentation setting out lines of accountability relating to this arrangement with the other vendors was not seen during the visit.

The FSI said he was not currently using these premises as a pharmacy and no other pharmacist had worked there since the conditions were placed on the premises and the FSI's suspension from the GPhC register. The pharmacy had insurance arrangements in place, including professional indemnity. The FSI had called them to ask questions and informed them that he had been suspended. The RP log was completed sporadically from 31 May 2023 and the most recent entry was 6 February 2024 after the FSI had been suspended. The RP notice was displayed. Private prescription records were written up manually in a register and included the required information. The most recent entry in the private prescription book was 28 June 2023. The pharmacy's fridge temperatures were monitored and recorded by a data logger.

There were seven private prescriptions for Ozempic issued by two pharmacist independent prescribers at another pharmacy and dated July 2023 when the National Patient Safety Alert (NPSA) was in place to protect supplies of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) medicines for treating people with diabetes. The prescriptions had not been annotated and private prescription records for their supply were not seen. The FSI said Ozempic was taken to the pharmacy which had supplied the prescriptions and where the Ozempic would be dispensed. The FSI said they had been sent to him by the other pharmacy to acquire more stock of Ozempic using British Chemist and All Chemists' quota, in spite of the National Patient Safety Alert. Records of the supply to the other pharmacy were not seen.

During the visit, the FSI received a call from the other pharmacy asking him to order Wegovy but the

FSI said their wholesaler would need a prescription because they limited the quantity which pharmacies could order. It was not clear how the Ozempic stock was transferred to the other pharmacy, what records were kept by the FSI, what happened to the prescriptions and if the people named on the prescriptions were aware their information had been shared. He said as far as he was aware the other pharmacy had people's consent to send their prescriptions to him to obtain Ozempic stock. But the FSI did not provide assurances that people's private information was protected when shared between the pharmacies.

The FSI had plans regarding services which may become available at the pharmacy and he was signposted to his insurers and the GPhC guidance for
registered pharmacies providing pharmacy services at a distance, including on the internet. The FSI still supplied non-medical items. If he cancelled an order, he could complete a notes section on the computer and describe the reason for cancelling.

The pharmacy did not supply controlled drugs (CDs). The available pharmacy records were generally complete. Following the visit, the FSI confirmed that the records for the phlebotomy service were compiled from copies of the pathology forms, appointment records on the booking system and results sent by email via the doctor's lab (TDL).

The pharmacy was registered with the Information Commissioners Office (ICO) and the FSI was aware of general data protection regulation (GDPR). The pharmacy collected confidential wastepaper to be shredded. The FSI had informed the providers of the prescribing software package that he was suspended and the data had been moved via a data storage license. The FSI had completed level 2 safeguarding training and discussed updating to level 3. The pharmacy had a safeguarding SOP. The FSI was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s staffing level is sufficient for the limited service available. The pharmacist is undertaking some appropriate training to help maintain his knowledge and skills.

Inspector's evidence

The FSI worked alone and had never employed another pharmacist at the pharmacy. He had appointed a new superintendent pharmacist. The FSI had read about antimicrobial resistance in January 2024. He had undertaken some training in the NHS Pharmacy First service and he had already trained in how to use an otoscope. The FSI had taken steps to keep his prescribing training current. He had not had much success to date but he was volunteering to observe during consultations.

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

Summary findings

The website is misleading in places because the wording does not fully reflect the restrictions in place on the premises and on the pharmacist. And some information is incorrect. But overall, the pharmacy's premises are clean, bright and secure.

Inspector's evidence

The registered pharmacy's premises were secure and generally clean but very cluttered in places. The pharmacy was well lit and steps were taken to make sure the pharmacy did not get too hot. The pharmacy had a public area, a counter, a small dispensary and storage space. There were some items stored on the floor behind the pharmacy counter. The pharmacy's consulting room was at the back of the premises and was a suitable clinical treatment room to undertake face-to-face services such as a phlebotomy service. It protected people's privacy. It was tidy and the FSI cleaned it weekly but he did not maintain cleaning records.

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 FSI explained that other vendors sell items through the British Chemist and All Chemists' website. People saw medicines such as Nurofen Plus on British Chemist and All Chemists' website but it was annotated to say that British Chemist and All Chemists did not sell at present. Another vendor would sell the medicine. The FSI re-iterated that these other pharmacies were responsible for what they sold. They made checks for identification and inappropriate requests such as multiple orders. The patient questionnaire was completed via the British Chemist and All Chemists' website but transferred to the associated pharmacy for assessment before the medicine was supplied. The website stated in 'Becoming a customer' that supplies may be made by another pharmacy. The website displayed an NHS logo on the 'Prescription' page which was misleading as the pharmacy did not have an NHS contract. The website included a chat function for people to use.

The complaints procedure on the website showed the previous address for the GPhC. And the SI details required updating. Information 'about us' was not fully up to date. And it was not clear why other pharmacies were selling via the website. The information on the website had been updated in places to say that 'Treatment medicines (POM) on our website are temporarily unavailable to purchase until further notice'. But the website information went on to say 'Our pharmacists are prescribers and prescribe for the most common minor ailments people suffer from'. As a part of our sexual health service, we also provide treatment for infections'. But the conditions did not permit the pharmacy to provide a prescribing service so prescriptions could not be written for any patient.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy is providing limited services due to conditions placed on the premises. People with different needs can access the pharmacy and its services. And they can purchase medicines from associated pharmacies through the pharmacy's website. The pharmacy obtains its medicines from reputable sources. And it generally stores them at the right temperature so it can be sure they are fit for purpose.

Inspector's evidence

The pharmacy had a manual opening door and a small step at its entrance, so it was not level with the outside pavement. But the FSI tried to make sure people could access the available pharmacy services. There were notices at the entrance with opening hours and inviting people to ring the doorbell to access the pharmacy. There was a ramp with anti-slip strips leading from the retail area to the back of the pharmacy's premises where people could use the consultation room. The pharmacy's sign listing services and how to book an appointment was at the pavement edge outside the front of the pharmacy. Another poster displayed details about booking on the website or scan a QR code. There was a poster regarding 'blood testing here.'

The FSI said pharmacy services were currently limited for people to access although a phlebotomy or blood testing service was available by appointment. The FSI dispatched labelled blood test vials with a completed pathology form to reputable laboratories for analysis or screening. For instance, blood samples were screened for the presence of allergens, or to monitor and detect conditions such as HIV and immunity.

The FSI said there were SOPs and records were maintained of tests. The FSI measured people's blood pressure which was free of charge. The pharmacy's website displayed a list of services offered by the pharmacy. If people clicked on 'online prescribing' and 'private clinic' services there were messages of apology and explaining 'All Treatment medicines (POM) on our website are temporarily unavailable to purchase until further notice'. But scrolling down there was information about being prescribed treatments for common minor ailments and infections (sexual health services) so the information was misleading and not in line with the conditions placed on the pharmacy.

The FSI explained that the Private Hospital Medication service was provided in exactly the same way as normal private prescriptions. Any patient who was being treated in a private hospital could bring their prescription to the pharmacy who would source the medicine for them from the wholesalers or manufacturer. The medicine could be posted or collected. And regarding the Aesthetics service which was on the website, the FSI explained that the Botox would be obtained from wholesalers or manufacturer after an external prescriber had prescribed it. Botox would only be administered by a healthcare professional. But at the time of the visit, the pharmacy was not permitted to provide any prescribing service.

Regarding Sexual Health Clinic & Testing, treatment would be prescribed/provided if a test was positive. And be in line with NICE guidelines but at the time of the visit, people were tested and referred to Better2know or another private prescribing service online, NHS 111 or their GP for treatment. Travel Clinic vaccinations were not available at the time of the visit. The pharmacy operated a partnership

arrangement with a physician who saw people in a private clinic, prescribed a treatment and if the patients agreed, British Chemist and All Chemists dispensed the prescription and posted the medicine via a 24-hour tracked courier.

The medical fridge was used to store some packs of Ozempic, a box labelled ‘LIPIDPANEL’, a box labelled ’HbA1c control’ and a few packs labelled ORORA foam refrigerant. The fridge temperatures were monitored and recorded by a data logger. Prescription medicines were not stored in an obvious place. The FSI said the pharmacy obtained its stock from Wardles and Bestway. However, there were multiple Alliance Unichem invoices charged to Mojji LS Ltd who owned the pharmacy. The pharmacy was signed up to the MHRA alerts and any MHRA product recall emails were first read and checked and filed into a separate folder called 'MHRA Acknowledged'.

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 pharmacy had hand sanitisers for people to use and personal protective equipment if needed. The FSI 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 equipment for the phlebotomy service and the FSI provided the SOPs following the visit. The pharmacy had bins for sharps and clinical waste disposal for the phlebotomy service it delivered.

The pharmacy restricted access to its computers and patient medication record system. And only an authorised person could use them when they put in their password. 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.