General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Smart Pharm Ltd, 787-789 Harrow Road, London, NW10 5PA

Pharmacy reference: 9011292

Type of pharmacy: Internet / distance selling

Date of inspection: 26/06/2024

Pharmacy context

The pharmacy is in a mixed commercial and residential area on Harrow Road near Kensal Green underground station in northwest London. The pharmacy dispenses private prescriptions and provides health advice. It sells over-the- counter medicines from the pharmacy's premises. The pharmacy does not dispense NHS prescriptions or provide NHS services at this site. The company that owns Smart Pharm offers access to a prescribing service to treat a range of conditions and medicines for through a website https://medsrus.co.uk. The pharmacy mainly supplies medicines to people living in the United Kingdom (UK). This was a targeted inspection in relation to the online prescribing service and its association with Smart Pharm Ltd. So some pharmacy services and some standards were not covered.

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 assess and document the risks involved in selling medicines online. And its written instructions for running the online prescribing service require a review to update how it manages those risks. The questionnaires are for specific medical conditions including some which are long term, but people do not have to consent to sharing information so the pharmacy may not always be able to verify people's medical information. Some of the points raised in the Prescribing policy for the treatment of Anxiety are not adequately covered by the questionnaire.
		1.2	Standard not met	The safety and quality of the pharmacy and its prescribing service is not regularly reviewed and monitored. The pharmacy and the online prescribing service does not routinely complete any audits to provide assurances that the service is safe.
		1.6	Standard not met	The prescriber does not always make a clear record setting out justification for prescribing, or not prescribing. Records of cancelled orders do not include the reason why the orders were cancelled.
		1.8	Standard not met	The pharmacy does not have a specific documented safeguarding policy to guide the team on the process to take in the event of a concern for vulnerable people associated with the online prescribing service.
2. Staff	Standards not all met	2.2	Standard not met	Team members require enrolment onto accredited training for their role in line with the GPhC's guidance on 'Requirements for the education and training of pharmacy support staff'.
3. Premises	Standards not all met	3.1	Standard not met	Some information on the website is missing or unclear such as information about prescribers and is not in line with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance,

Principle	Principle finding	Exception standard reference	Notable practice	Why
				including on the internet'
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The prescriber's decision to refuse treatment or refer people, and verification of information in line with prescribing policy are not always documented.
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 set out its processes in writing for running the pharmacy and in particular, its online prescribing service. It does not regularly review those written instructions to make sure they are up to date and appropriately identify and manage the risks involved in providing its services. The pharmacy does not adequately assess the risks involved in selling medicines online and it does not routinely document risk assessments (RAs). The pharmacy does not ask for people to share information so it is unable to independently verify their medical information. And people's doctors may be unaware of treatments they obtain elsewhere. This means there is a risk the pharmacy could supply medicines innappropriately based on false information. The pharmacy's consultation records are inadequate as they do not always include information on counseling provided or details of refusals to supply medicines. The pharmacy does not have a specific documented safeguarding policy to guide the team and protect the welfare of vulnerable people associated with the online prescribing service.

Inspector's evidence

The company that owned this pharmacy, Smart Pharm Ltd [GPhC premises number 9011292] also owned another pharmacy in nearby Park Royal [GPhC premises number 1122566]). A routine inspection was conducted at this pharmacy in January 2024 and rated ‘standards met’. It since transpired that an online prescribing service and a ‘walk-in clinic’ which people could attend had been running from this premises. The pharmacy dispensed prescriptions which were issued by the superintendent pharmacist (SI) who was an independent prescriber and the sole prescriber for this service based at this branch of the pharmacy. The SI stated that he had started dispensing medicines for this prescribing service in the past few months. The website offered treatments for chronic health, general health, men’s health, sexual health, travel, wellbeing and women’s health. People using the website could select a condition about which they could read a brief explanation. The prescribing service available through the website did not allow people to select a medicine before starting a consultation. They could view the available medicines but they had to complete a short assessment to help the SI recommend the right treatment. They could click on specific medicines with prices for more information. The assessment questions were in three sections on general health, the conditions and treatments. There was no evidence of risk assessments (RAs) being completed before the service was introduced.

The website did display medicines which required monitoring. The SI had reviewed the risks associated with painkillers which had resulted in the pharmacy not supplying painkillers through the website. Some medicines available through the online prescribing service were liable to abuse or misuse. This included propranolol, cyclizine and medicines for weight loss such as Ozempic, Saxenda and Mounjaro. The SI did not have standard operating procedures (SOPs) specific to the website or document risk assessments (RAs). After the visit, the SI produced a risk assessment MedsRus-SOP 2 – Risk Assessment for every order placed on the website to identify the risks and provide solutions to mitigate them. The RA covered identifying people placing orders, accepting payment, refusing approval of an order and documenting the reasons, approving an order and generating a prescription. Finally, it signposted the pharmacy team to dispensing SOPs and covered dispatch of the items with the tracked courier.

The SI supplied specific questionnaires for four conditions. The questions relevant to each condition were not always very detailed and for instance, the questionnaire for asthma did ask if the person took other medicines but not specifically a steroid inhaler. It asked if the person used their salbutamol inhaler four times in 24 hours but not about daily use or middle of the night. The contraception-specific

questionnaire covered a range of risk factors when taking oral contraception including age and smoking status. The questionnaire finished with a declaration stating the person would read the information leaflet supplied, they were over 18 years old and it was for their own use.

People under 18 years were not prescribed medicines through the online prescribing service. People were asked their age as part of the consultation process, and their identity (ID) was verified. The pharmacy computer system merged duplicate accounts for the same person. The SI said that people were required to upload photo ID and their NHS number was confirmed. The pharmacy had access to the National Care Records Service (NCRS) so relevant details could be checked. It was unclear whether consent from people was obtained for this activity. The online prescribing service gave people the option to consent to sharing information with their GP but it was not mandatory. The SI said that few people consented to this so most people's usual GP was not aware of treatments that they were receiving from this pharmacy or other pharmacies.

The SI said he monitored sales and maintained records of cancelled orders, but he did not include the reason why the orders were cancelled. Reasons for cancelling included orders being placed too soon after the last order or failure of identification checks. He knew which treatment was most often supplied to people through the website and explained which conditions and treatments would require monitoring to ensure safe supply. For instance, asthma and human immunodeficiency viruses (HIV) infection. A risk register was not seen during the inspection. The SI had designed the website questionnaire, so it was in line with available guidance. And he explained that the questionnaire was a risk assessment. When prescriptions came through on the computer system, the patient history was checked, and the medicines were dispensed but the prescriptions were not printed.The website stated that some medicines it supplied, such as weight-loss medicines, were licensed to treat the conditions they were prescribed for, and some medicines were used off-label or not within the terms of their license.

The SI said people who were using weight loss treatments had a treatment plan and monthly checks were made on weight and side effects. Ozempic (Semaglutide) and Mounjaro (Tirzepatide) were prescribed and supplied through the service for weight loss. Ozempic was licensed to treat people with diabetes and not licensed for weight loss. So it was being prescribed off-label by this prescriber. A National Patient Safety Alert continued to be in place for these kinds of medicines in response to a national shortage affecting people who needed them to treat type 2 diabetes. NICE guidance for prescribing Mounjaro had recently been updated. The SI used the answers provided by people through the consultation process to prescribe and supply these medicines. There was no independent verification of people's weight, so for example, no photo evidence of their weight being obtained or the option to request a video call if more information was needed. So, there was a risk people could provide false information to obtain medicines.

The SI explained that a medicine used to lower blood pressure was available on the website. And he had reduced the quantity which could be supplied because some people may try to obtain it and use it inappropriately. Propranolol was licensed for a range of indications, but it could also be misused. The SI was aware of overdosing with this medicine and the potential suicide risk. He repeatedly mentioned one case where a patient had died after they had been prescribed and supplied this medicine through an online service. The SI prescribed and supplied this medicine for anxiety. He described previously supplying propranolol in greater quantities (such as 84 tablets at a time) but he said that he had now limited this to one pack, i.e., 28 tablets.

There were some concerns noted with the pharmacy's consultation questions to obtain propranolol. The SI said that the strengths of propranolol he prescribed were 10mg, 40mg and SR 80mg. The pharmacy usually completed five to six orders a day via the website. The SI gathered the information for

repeat orders in the same way as he did for every order. There was also a minimum of one month gap between orders. Although propranolol was licensed for anxiety it was not recommended by NICE. The example of a questionnaire supplied during the visit, included conflicting information, incomplete sentences, jargon and the ability to change answers in order to progress. The section with a list of contraindications finished mid-sentence. The section asking about medications may be difficult for people to understand. And may have been better asking about any other medicines they took from any other source such as over-the-counter, on prescription or herbal.

There was conflicting information within the questionnaire. For example, the questionnaire asked 'Have you ever been diagnosed with a mental health condition?' People could answer' Yes or No'. If 'Yes' was selected then further information could be supplied. However, later in the questionnaire there was a statement:' I have previously been diagnosed with anxiety and prescribed this product by a healthcare professional'. To which people could respond 'Yes or No'. The only way to move forward with the consultation was to reply 'Yes'. The conflict was then at the question 'Have you ever suffered from any mental health disorder? Such as Depression, Anxiety disorders, Post traumatic stress disorder, Obsessive-compulsive disorder, Bipolar and schizophrenia'. If 'Yes' was chosen here, the supply would not be made. So people could move forward with the consultation by replying 'No.' Although the questionnaire asked for consent to share the information with the GP, it made it clear this was optional. And did not mention the risks of not sharing this information to allow people to make an informed decision. There was no risk assessment to determine if a supply should be made where there was no consent to share information.In line with GPhC guidance for registered pharmacies providing services at distance, including on the internet: prescribers must be satisfied that information they have received is reliable and that they can independently verify the information the patient has given to them to satisfy themselves they are making a safe prescribing decision. Consent to share information with the GP would mean the prescriber could verify information and endorse the decision to prescribe or not prescribe. The prescriber must make a clear record setting out their justification for prescribing, or not prescribing.

Some of the points raised in the Prescribing policy for the treatment of Anxiety were not adequately covered by the questionnaire such as hyperthyroidism, substance-induced anxiety and anxiety tachycardia and it was not clear how they were diagnosed. The Prescribing policy mentioned prescribing directions for generalised anxiety disorder (GAD) yet the questionnaire effectively excluded it where people had to reply 'no' to the question about symptoms relating to GAD. The policy referred to assessing treatment response within six to twelve months, adjusting dose, monitoring blood pressure, heart rate, and adverse effects but it was not clear who would do this especially if the information was not shared with the GP. At the inspection, the online prescribing service was also offering an anti-HIV (Human immunodeficiency virus) medicine for post-exposure prophylaxis in an emergency. The SI had not prescribed this for anyone, and no supplies of this medicine had been made. It required a blood test but the pharmacy did not provide the blood test. The SI provided an explanation of his reasoning for offering this medicine. However, after discussing the risks, side effects and ongoing monitoring required for this medicine, the SI deleted the medicine and removed its availability through the prescribing website during the inspection. Whilst it was still listed under 'Sexual Health' on the website, clicking on this no longer brought up a product to view. The pharmacy business continuity plan was retained in the SOP folder. The pharmacy generally did not participate in audits to monitor the safety and quality of the online service such as near miss audits or clinical audits.

At the point of inspection, the pharmacy had no standard operating procedure (SOP) which was specific to this online prescribing service or risk assessments (RAs) available to help provide guidance and identify and manage the risks associated with this service. Audits were not seen to have been completed to verify the safety and quality of the service being provided. Consequently, there was no effective oversight, analysis of the prescribing habits taking place, or analysis of the medicines being

supplied for this service. The SI stated that the online consultation was the RA. This was not in line with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet'. Without documented and specific RAs, there was no evidence that the SI was making prescribing decisions based on clear inclusion and exclusion criteria or what he did in the event of any cautions identified from the questionnaire. The SI said that he had checked national guidelines and prescribing was in line with these. However, the pharmacy did not have a prescribing formulary or prescribing policy in place which could help the SI to demonstrate how he practised safe prescribing.

Prescriptions for MedsRus were processed at both pharmacies owned by the same company. This pharmacy was used as a collection point but the processes involved in running both pharmacies under the current business model were not set out in the SOPs. The SOP for transfer of medicines between both pharmacies was not seen. There was no audit trail for medicines being transferred from one pharmacy to the other. But the pharmacist explained the procedure and the audit trail indicating safe and effective delivery of prescriptions from the pharmacy to people's homes or the other pharmacy. The delivery record sheets were retained at this pharmacy. The website displayed an email address and telephone number and details of how and where to contact the customer service team. It detailed Terms and Conditions which included the complaints procedure, returns and the privacy notice.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register and CDs were audited regularly to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. If the treatment was approved following the consultation, the website had an in-built function which automatically generated private prescriptions. The pharmacy kept records for the supplies it made of private prescriptions but the prescriber details were not correctly recorded. There was also no evidence of any consultation notes being made by the prescriber, this included no documented details of refusals and no documented evidence of people being counselled before or after a prescription was issued.

The pharmacy was registered with the Information Commissioner's Office (ICO) and displayed a privacy notice. It disposed of confidential wastepaper securely. A team member was aware of her role in protecting patient confidentiality. The pharmacy computer system was password protected and not visible to unauthorised people. The SI had completed level 2 safeguarding training and described safeguarding scenarios in relation to refusing treatments for people under 18 years old, even when they had a parent with them who provided consent. The SI verified ages by asking for identification documents when he felt this was necessary. The registered pharmacy premises had a sign advising the availability of a chaperone. The RP was signposted to the NHS safeguarding App.

The SI had been trained to safeguard vulnerable people through the Centre for Pharmacy Postgraduate Education (CPPE) and he could easily access details about various local safeguarding agencies across the UK. However, the pharmacy did not have a specific documented safeguarding policy to guide the team on the process to take in the event of a concern for vulnerable people associated with the online prescribing service. The pharmacy had therefore, not specifically addressed any potential risks associated with dispensing medicines against private prescriptions for this service. A safeguarding SOP set out what to do if the pharmacy team aware had a concern about the safety of a child or a vulnerable person.

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

Summary findings

The superintendent pharmacist (SI) manages the prescribing service workload. The company employs support staff to dispense and dispatch prescriptions in the pharmacy without having enrolled them on accredited training in line with their roles. The SI completes training to keep up to date and support how the team provide services.

Inspector's evidence

The company employed several people. On the day of the visit the pharmacy team consisted of the SI and two support staff members. The SI supervised and oversaw the supply of medicines from the website and was supported by a medicines counter assistant at the pharmacy. It was necessary to visit both sets of premises regarding the operation of the website.

The SI's initial clinical area that he was competent to prescribe in was for musculoskeletal pain, and dermatology. He described expanding his scope of practice through completing relevant courses online to develop his expertise. This was through online courses via pharmacy support organisations, and he described signing up to an online organisation for medical education (iheed) to gain accredited qualification and specialist skills he required. Certificates obtained to verify qualifications obtained were on display. As the online prescribing service was owned and managed by the SI, there were no financial incentives or targets. If the SI was away on holiday for example, the online prescribing service was not provided. There were no formal appraisals but team members had regular contact with the SI, felt able to provide feedback and were aware of the whistleblowing policy.

During the visit to the premises, there were two members of staff present alongside the SI who was the regular RP. The inspectors were told that both staff had worked at the pharmacy for between four to six months, and they assisted with dispensing. However, neither staff member had been enrolled onto any accredited training for this role. This was not in line with the GPhC's guidance on 'Requirements for the education and training of pharmacy support staff'. This specified that support staff must be enrolled on aa accredited training course as soon as practically possible and within three months of starting their role. This situation had also previously been highlighted to the SI by the area inspector at the last inspection.

The SI described relevant experience he had gained in other healthcare settings. More recently the SI had spent time at a surgery under the supervision of a GP where he assessed people's needs and prescribed treatment for anxiety issues. Additionally, the SI participated in ongoing professional development to stay updated in mental health care. And had joined a tutor led course for mental health conditions.All aspects of this Principle were not inspected.

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

Summary findings

The pharmacy is light, bright and of sufficient size for the current workload. Following the inspection visit, some of the information on the website which was not accurate and may have been misleading is now updated. The pharmacy's website includes some unclear information about its prescribers, so people won't know who is responsible for the online services. Missing information means that the website is not fully complant with GPhC guidance for registered pharmacies providing services at a distance including on the internet.

Inspector's evidence

The SI was based at these premises from which he provided the prescribing service. It had a consultation room which was clean, tidy, and signposted, so people could have a private conversation with a team member. It displayed a notice advising the availability of a chaperone. The dispensary had limited workspace and storage available. Worksurfaces in the dispensary were clean and clear. There were treatment rooms at the back of the pharmacy's premises but these were not part of the registered premises so they were outside the scope of this inspection. People accessed the treatment rooms via the pharmacy. The website for the services in these treatment rooms was not linked to the registered pharmacy and as such outside the jurisdiction of GPhC.

The pharmacy's online prescribing service was accessed via https://medsrus.co.uk/ which initially displayed inaccurate information as it stated it was the pharmacy with the GPhC registration number (1122566) of the company's other pharmacy given. The GPhC's voluntary logo also took people to the registration details of the other pharmacy premises (1122566) given. After raising this with the SI, this has subsequently been changed to reflect the correct details and premises. The website did not allow people to choose a medicine prior to starting a consultation and had no direct reference to any prescription-only medicines (POMs). The pharmacy's registered address, email address and telephone number along with details about the company and SI were easily available.

However, there was further information missing which meant that the website was not fully compliant with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet'. Whilst there was a 'contact us' section, there were no specific details of how users of this service could give feedback and raise concerns. Terms & Conditions Part 9 – Complaints Procedure explained how people could complain. As people were prescribed medicines following an online consultation, the website did not prominently display the name of the prescriber, the prescriber's registration number and the country they were registered in, the kind of prescriber i.e., a pharmacist independent prescriber and no information about how to check the registration status of the prescriber.

People could not choose a prescription-only medicine before starting an online consultation. Following the visit, some of the website information associated with the pharmacy had been clarified in line with GPhC guidance for registered providing pharmacy services at a distance, including on the internet. It was not clear who prescribed medicines. And the GMC doctors were not identified. The website referred to completing an assessment for propranolol to treat anxiety as follows. The information would be reviewed by a GMC registered doctor or a specialist Independent Pharmacist prescriber, prescribing under DSL Medical, an EU healthcare provider. But Companies House referred to DSL

Medical as ‘dissolved’.

The website Terms and Conditions said Smart Pharm was a fully regulated company by the relevant UK medical bodies. It offered information, advice and treatment for a range of medical conditions. This service 'is provided by qualified UK doctors registered with the General Medical Council (GMC) and comply with GMC ('Good practice guidelines'). Our dispensing pharmacy is regulated by the General Pharmaceutical Council (GPhC) and can be trusted to deliver a high level of service by our qualified pharmacists.' Missing information could be misleading and meant that the website was not fully compliant with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet'.

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

Summary findings

The pharmacy does not keep adequate records of the decisions it makes to refuse treatment or refer people elsewhere. And it doesn't adequately document any verification of people's information as it should, in line with its prescribing policy. The pharmacy makes its services accessible to people, in person, by telephone and online. It gets its medicines from reputable sources and it stores them appropriately and securely. The pharmacy delivers medicines to people in their homes or to the other pharmacy's premises where they can be collected. The website and the online services are available twenty-four hours a day. Medicines are supplied to people in the UK who use the online prescribing service, via a courier with tracking facilities. And in packaging which helps keep medicines at the correct temperature. The pharmacy makes sure people have the information to use their medicines safely.

Inspector's evidence

People visited the pharmacy and its services via the phone or email. The dispensing labels showed the 'medsRus' name, along with the pharmacy's address, phone number and website details so people could contact the pharmacy. The online prescribing service was available to people to access 24 hours a day, but the service was manned by the SI from 9am to 5pm. The pharmacy received prescriptions from the online prescribing service electronically. The SI described the systems being used as secure and encrypted.

The workflow involved the SI reviewing people's consultation answers, then accepting the order or rejecting it. If accepted, staff generated the dispensing labels, dispensed the medicine(s), which was checked for accuracy by the SI before it was packed for delivery. The dispensing labels being used at the point of inspection listed the company's other pharmacy's address. This was inaccurate, misleading, and not in accordance with legal requirements. After discussing this with the SI, he agreed to stop using the labels. And following the visit the SI sent a screen shot of the medsRus dispensing labels showing medsRus with the address of premises 9011292.

The website displayed customer service details at the address of the other pharmacy in the business park, info@medsrus.co.uk and a phone number. But elsewhere on the website, the details given were sales@medsrus.co.uk with the same phone number but the address of this pharmacy. This may be misleading to people who access the pharmacy and its services. The pharmacy delivered medicines to people in the UK who used the online prescribing service, through a courier service (Royal Mail). This service had tracking facilities. To help keep medicines that required refrigeration cool during the delivery process, ice packs were used. The SI had assessed the reliability of the ice packs. For failed deliveries, three attempts were made before the medicine(s) was sent back to the pharmacy so no medicines were left unattended. The pharmacy signposted people to their local pharmacy if they required disposal of medicines which had been delivered. The delivery record sheets were retained at the pharmacy.

The online prescribing service was provided to people aged 18 or over. People were required to set up an account when they started using the online service. They had to use a form of identification which showed their age such as a UK driving license or passport. And provide their NHS number so the SI could view their National Care Record and verify information supplied by the person on completion of a questionnaire. People usually needed to complete an online questionnaire when requesting a

treatment. If a person changed their answers this was flagged to the prescriber. The responses submitted were reviewed by the SI who approved and generated a prescription if satisfied with the responses. And a patient could be contacted if further information was needed or they were signposted to another clinician or provider.

If a prescription was issued it was sent to either pharmacy to be dispensed. After checking the questionnaire and approving the prescription, the prescription information was entered into the pharmacy computer. A member of the pharmacy team picked medicines and scanned the barcodes on the packs. The dispensing labels were attached and after a final check, the items were packaged, addressed and sealed ready for collection by Royal Mail. Packages were tracked and returned to the pharmacy following unsuccessful attempts to deliver to the purchaser.

The website displayed treatments for multiple conditions. Some were acute conditions such as simple urinary tract infections treated with trimethoprim or nitrofurantoin. And propranolol was prescribed for anxiety. People could select oral contraception although not emergency hormonal contraception. The website listed chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD) for which salbutamol inhalers (Ventolin Evohaler and Salamol) were prescribed. Under general health, cyclizine for nausea was listed. There were also medicines for erectile dysfunction, travel health, contraceptives, and medicines for weight loss such as Orlistat, Saxenda and Ozempic (See below about Mounjaro). The pharmacy did not prescribe or supply any controlled drugs (CDs) through the online prescribing service. The SI confirmed that for asthma or COPD only salbutamol inhalers were supplied and that he had not co-prescribed any steroid inhalers. This could bring into question the management of these patients' asthma or COPD. The SI said that people prescribed this inhaler were not requesting repeat quantities, they only purchased one inhaler and that this was in an emergency situation for example, if people had run out of their inhaler. The SI also stated that if people requested to order more than one inhaler, then he would refer them to their usual doctor. However, this was not documented anywhere else to help verify that this was the pharmacy's policy to do so.

For people prescribed Ozempic and Mounjaro for weight loss, the SI said that people's past medical history and weight was checked from the consultation process. However, as stated under Principle 1, there was no independent verification of this information, so the pharmacy was dependent on people giving accurate details such as the weight lost. Every month, the SI described making a telephone call to people prescribed this medicine to check side effects and review details. However, this information was not documented to help verification. The SI stated that people prescribed these medicines did not receive repeat supplies after six months due to the high-cost factor involved. The SI also provided some examples of when he had refused to prescribe medicine(s) for people. However, relevant details to help verify or justify these were not documented.

There were systems to identify people that had created multiple identities or accounts. And, when identified, these accounts were blacklisted so that any activity was flagged to the appropriate teams. All UK patient identity checks were carried out using a third-party identity checking service. This checked the person's identity and age using electoral roll and credit checks. If the checks failed, or the person was not from the UK, a member of the customer service team would ask them to provide additional proof, such as a copy of their passport or driving licence, to confirm their identity and age. People provided their consent for the service, including authorising the pharmacy to dispense their medication, by agreeing to accept the terms of service during the ordering process. Consent to share relevant details with people's regular GP was not mandatory. The online prescribing service gave people the option to consent to sharing information with their GP. The SI said that few people consented to this which could mean that most people's usual prescriber was not aware of treatments that they were receiving from the pharmacy.

People who were prescribed weight loss medicines were monitored. And this included an up-to-date full-body photograph, the person's height, other relevant history and a summary of their weight over the treatment period. People were supported with their weight loss journey. They were counselled on how to use the prescribed medicine properly before and after a supply was made. And they were supported further by clinicians who specialised in nutrition and exercise. The superintendent pharmacist described a few recent clinical interventions where they prevented the inappropriate supplies of medicines including a UTI treatment for an elderly patient. And the PMR system was routinely used to record the clinical interventions made by the pharmacy team.

The pharmacy delivered medicines to people in the UK who used the online prescribing service, through a courier service (Royal Mail). This service had tracking facilities. The pharmacy used discreet packaging and to help keep medicines that required refrigeration cool during the delivery process, ice packs were used. The SI had assessed the reliability of the ice packs. For failed deliveries, three attempts were made before the medicine(s) was sent back to the pharmacy. No medicines were left unattended. The pharmacy signposted people if they required medicines to be disposed of.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock which was arranged tidily on the shelves in the original manufacturer's packaging. The SI checked the expiry dates of medicines but a small number of date-expired medicines were removed from the stock. And checking the expiry date as part of the final check when dispensing them was discussed. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. CDs were generally stored in line with safe custody requirements.

The pharmacists received alerts and recalls about medicines issued by the Medicines and Healthcare products Regulatory Agency (MHRA) on their own phones. So the alert may not be available to a locum pharmacist and there was no system for notifying the MHRA if there were concerns about the medicines it supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services. And the team uses the equipment in a way which protects people's private information.

Inspector's evidence

The pharmacy's computers and PMR system were password protected. And access to them and the company's other computer systems was restricted to authorised team members. And it collected confidential wastepaper for secure disposal.

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.