General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nomad Pharmacy, Room 12-14 Lower Ground Floor, 65 London Wall, London, EC2M 5TU

Pharmacy reference: 9011311

Type of pharmacy: Internet / distance selling

Date of inspection: 24/08/2023

Pharmacy context

The pharmacy is in an office building on a busy street near Liverpool Street station. It is a distance-selling pharmacy (www.nomadtravel.co.uk/pharmacy) which specialises in travel health and is part of the Nomad travel clinics. The pharmacy dispenses private prescriptions only. The pharmacy is closed to the public and medicines are delivered to people via courier.

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 met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website allows people to select a couple of prescription-only medicines, prior to completing a consultation with a prescriber.
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

On the whole, the pharmacy appropriately identifies and manages the risks associated with its services. The pharmacy audits its prescribing service to help ensure that supplies are appropriate. It protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people. The pharmacy largely identifies and manages the risks associated with its services to help provide them safely.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (SOPs). The pharmacy issued travel medicines against private prescriptions issues by UK-based prescribers. The superintendent pharmacist (SI) was a pharmacist independent prescriber and issued most of the prescriptions. The pharmacy occasionally dispensed prescriptions issued by doctors or nurses who worked in the travel clinics. The pharmacy had recently undertaken an audit on the use of post exposure prophylaxis (PEP) issued by the pharmacy. It was a joint audit between the SI and the other prescribers. The appropriateness and quantity of PEP prescribed was audited. The SI said that the outcome of the audit showed that all PEP supplies considered as part of the audit were appropriate.

The pharmacy had a way to record near misses, where a dispensing mistake was identified before the medicine had reached a person. And dispensing errors, where a dispensing mistake had reached a person. The SI explained that these would be highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members would be responsible for identifying and rectifying them. The SI said that there had not been any recent near misses or dispensing errors, and that might be due to the pharmacy stocking a limited number of different medicines. And there were very few distractions while team members were dispensing medicines. Any incidents would be discussed at the regular clinical governance meetings. Any concerns or complaints from patients would also be discussed during the meeting. The SI said that there had not been any recent complaints and details about how people could complain where on the pharmacy's website. He said that the pharmacy's head office would inform him about any complaints.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the pharmacy was free from clutter. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser knew what tasks she should not undertake if there was no responsible pharmacist (RP) signed in, or if the pharmacist was not in the pharmacy. The SI said that the pharmacy would not open if there was no pharmacist available. And that the pharmacy was looking to train a second pharmacist so that cover could be provided if needed.

The pharmacy had current professional indemnity insurance. The SI confirmed that the insurance policy covered all activity undertaken in the pharmacy. The private prescription records were mostly completed correctly. The right RP notice was clearly displayed, and the RP record was completed

correctly.

The pharmacy disposed of its confidential waste appropriately and computers were password protected. And team members had undertaken training about how to protect people's personal information.

Team members had completed training about protecting vulnerable people. And the SI had completed the Centre for Pharmacy Postgraduate Education Level 3 training. The SI said that there had not been any safeguarding concerns at the pharmacy. And he would refer any concerns to the relevant agency where needed. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one trained dispenser working alongside the SI during the inspection. And they were both employed to work at the pharmacy on a full-time basis. The pharmacy was up to date with its workload and items were being dispatched in a timely manner. The SI said that the pharmacy's website would be updated to inform people about any delays due to staffing issues. And leave was planned, which helped the team ensure that items were sent prior to the leave being taken.

The SI said that team members completed relevant training before a new service was implemented. The SI and dispenser explained that they read magazines and articles about travel health to help keep their knowledge up to date. And the dispenser had spent time with some of the nurses in their travel clinics to help increase her knowledge in these areas. The SI was an independent prescriber and had specialised in travel medicine and travel health. He said that he only prescribed within his scope of practice. He had recently completed the yellow fever training. And had also completed post diploma travel medicine course. He had attended multiple expeditions training courses and a medicine in the wilderness conference. He had attended meetings and training events provided by the Royal Geographical Society.

The SI was aware of the continuing professional development requirement for professional revalidation. He felt able to make professional decisions and he said that targets were not set for team members. Team members regularly attended meetings with team members that worked in the travel clinics. This allowed them to discuss any issues or concerns. The dispenser felt comfortable about discussing any issues with the SI and had ongoing performance reviews with him. The SI said that the pharmacy had a good working relationship with other departments in the company and regularly shared information to help ensure that the services were safe.

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

Summary findings

The pharmacy’s website allows people to select a couple of prescription-only medicines, prior to completing a consultation with a prescriber. This increases the risk that people receive treatment which is not clinically appropriate. And the website does not provide the correct details of the pharmacy’s superintendent pharmacist. The premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy’s website had been changed since the previous inspection, but there were two prescription-only medicines that could be selected and ‘put in the basket’. People were then directed to pay for the medicines prior to a consultation being carried out. And the correct details of the SI were not displayed on the website. The SI said that he would speak with the pharmacy’s web developer to amend the SI details and to update the website so that a consultation was carried out before a prescription-only medicine could be selected.

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout. The room temperatures were suitable for storing medicines on the day of the inspection. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People can access the pharmacy's services.

Inspector's evidence

The pharmacy provided its services at a distance. Services and delivery timelines were advertised on the pharmacy's website. The pharmacy carried out checks to ensure that people receiving their medicines from the pharmacy were who they said they were. People using the pharmacy were largely from television companies, non-governmental organisations, or travel companies. The pharmacy supplied travel kits, first aid kits and travel medicines, including antimalarial tablets. The travel kits contained a variety of items including some prescription-only medicines.

The SI explained the usual process organisations followed to access the pharmacy's services. It usually started with an email from a production company providing the names and contact details of the people travelling. The pharmacy then sent each person listed a link to follow online. The link directed them to complete a health questionnaire, and it included information such as the person's name, date of birth, address, health information, allergies, and any medication they were taking. The SI said that he reviewed the completed questionnaires and decided on which anti-malarial medicine was most suitable for each person. Following this decision, he would then issue a prescription for that individual. Medicines were then dispensed against the prescription and send via Royal Mail next day registered delivery. Individual tracking numbers for the packages were emailed to each person once the medicines had been posted.

People could purchase travel kits via the pharmacy's website, and they could also request anti-malarial medicines. People could search for the medicine they wanted, and they were provided with information about it. Most of the time they were then taken to the conditions page and asked to complete a consultation before being able to select the medicine they wanted. The inspector found two medicines that could be added to basket and then appear to have been able to be purchased before a consultation was carried out. The SI said that these were errors on the website and one of the medicines on the list was a test product and should not have been on the live website. He said that he would contact the web developer and have that one removed and the other one changed so that a consultation was needed before being purchased. The SI explained that he reviewed the consultation questionnaires before he issued a prescription. And he would contact a person if there were any queries about the information they had provided. He checked the online BNF for drug interactions between any medication the person was already taking, and the requested medicine. And any interventions were recorded on the person's notes.

The pharmacy did not prescribe medicines for use in the UK and people had to confirm that they would not use the medicines in the UK before the medicines were supplied. And people were required to have travel insurance and access to a doctor over the telephone. The pharmacy used an in-house formulary when prescribing medicines and there had not been any reported side effects to the medicines supplied by the pharmacy. And there were two standard kits that the pharmacy issued to people. The

‘worldwide travellers’ diarrhoea kit’ contained azithromycin for severe travellers’ diarrhoea and the ‘ultimate travel kit’ also contained clarithromycin, a broad-spectrum antibiotic. The pharmacy followed standard good practice guidelines when supplying these kits. People were provided with written information about how to self-diagnose and were told not to take the antibiotics for mild to moderate diarrhoea. People were required to seek medical advice before starting the antibiotics either over the telephone or in person.

The pharmacy followed the British Mountaineering Council guidance when prescribing acetazolamide for high altitude sickness. The pharmacy dispensed some medicines for post-exposure HIV kits and PEP kits. The PEP kits were to be taken abroad by aid workers in case of needle stick injury. Prescriptions for these kits were issued by doctors as part of a screening service. The prescriptions were then dispensed in the pharmacy and checked by the SI.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. Stock was stored in an organised manner in the dispensary and expiry dates were checked regularly. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy was closed to the public which helped to protect people’s personal information. The pharmacy’s phone was portable so it could be taken to a more private area if needed. Confidential waste was removed by a specialist waste contractor. Team members had access to up-to-date reference sources online. And computers were password protected.

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.