General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Quick Meds, 153A Stamford Road, Birmingham, West Midlands, B20 3PS

**Pharmacy reference:** 9011331

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 13/10/2021

## Pharmacy context

This is a distance selling pharmacy which opened in January 2020 and it provides services at a distance to patients through its website www.quickmeds.co.uk. The pharmacy premises is not open to members of the public, so it delivers prescription medicines directly to patients. The pharmacy has an NHS contract and offers a pharmacist independent prescriber led prescribing service based onsite. The website offers prescription and non-prescription medicines for a range of conditions, but it mainly supplies medicines to support weight loss. The inspection was completed during the COVID-19 pandemic.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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 met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | N/A | N/A | N/A |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

Members of the pharmacy team follow written procedures and protocols to make sure they work safely. The pharmacy identifies and manages the risks associated with its services to make sure people receive appropriate care. It regularly reviews its systems and processes and makes changes to improve them. But the pharmacy's prescribing service does not always inform a person's doctor when it supplies them with weight-loss medication. This means their doctor may not always know what medicine the person is taking or how it is affecting them. And the prescriber's records do not always include enough information to show why the medicines they prescribed were the most suitable for people.

### Inspector's evidence

The pharmacy had two parts to the business; the supply of NHS prescriptions and a prescribing service which supplied prescription only medicines (POMs) to people in the UK through its website www.quickmeds.co.uk (the "website"). These prescription supplies were made after a consultation with a pharmacist independent prescriber (PIP). The prescribing service was accessed via the website and people could contact the pharmacy to speak to a pharmacist or the PIP before starting an online consultation if they had any questions. The online prescribing service had been operating since the start of 2021. Various contact methods were available and advertised on the website. Four pharmacists worked regularly at the pharmacy. The PIP was also the superintendent pharmacist (SI) and a company director.

A risk register was used to help the pharmacy team to identify, assess and manage the risks associated with the pharmacy services. The risk register covered a wide range of identified risks including staff training, signposting to other sources of information, providing counselling advice, supply of unlicensed medicines and clinical review meetings. The risk register was updated, and new risks were added when they were identified. Some underlying risks associated with the nature of the business model and types of medicines supplied had been noted but not been fully considered. For example, the risk that people suffering with an eating disorder might not be truthful when filling in an online questionnaire to obtain weight-loss medicines. The PIP tried to mitigate this risk by insisting that he spoke to every new patient that requested an unlicensed weight loss medication, prior to issuing a prescription. But the pharmacy did not use any other means to confirm a person's weight or medical history, such as video consultations or routinely accessing Summary Care Records (SCR).

There were regular reviews of the services provided by the pharmacy. Some of these were documented in the form of internal audits. Recent audits included the number of rejected private prescription requests and the reasons why, the number and types of supplies made and dispensing accuracy. Informal reviews and feedback had led to changes to the website flow and the questions asked during the online consultation.

Each of the prescription only medicines available on the website had an accompanying treatment protocol available to the prescriber. Additional risks associated with the supply of each of the medicines were written into the treatment protocols. The protocol included sections such as, the clinical condition it could be prescribed for, inclusion and exclusion criteria, cautions, counselling for patients and the

resources used to develop it. Treatment protocols for unlicensed indications were clearly marked as such, together with a comprehensive list of resources, including clinical trials information and links for further reading. Whilst the treatment protocol for Ozempic clearly stated that weight loss was an unlicenced indication, it was not clear whether licensed alternatives were discussed with the person before suggesting Ozempic, and the reason for prescribing an unlicensed medicine was not documented in the clinical notes.

Anyone using the service for the first time, or an existing user that had changed their personal details, had their identity checked using an identity checking service. The name, date of birth and the post code were checked, and the outcome was flagged either red, amber or green and given a score. A red or amber outcome would show there was incorrect information entered. The pharmacist then contacted the person to ask for them to submit additional proof of identification or checked the information that had been entered before a prescription could be issued. The pharmacy systems showed how many orders had been made by the IP address and also the number of orders that had been supplied to a particular postal code. This information was used by the PIP, and the pharmacist dispensing the prescription, to check that orders were genuine.

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were reviewed and updated on an ongoing basis. The pharmacists had developed the SOPs to reflect the pharmacy services provided. Roles and responsibilities of staff were highlighted within the SOPs and signature sheets were used to record staff training.

In addition to the SOPs, there were flow diagrams for the pharmacist who was undertaking a clinical check of prescriptions issued by the PIP to follow. This acted as an additional check of the information provided by the patient, confirmed that the PIP had followed the agreed process prior to prescribing and the ID check had been passed. The PIP did not undertake the clinical check of prescriptions that he had written. He occasionally dispensed prescriptions he had written however, the risk involved in this was mitigated by the in-built systems in the patient medication record (PMR). The PMR used barcode scanning technology during the dispensing process to identify near misses and reduce the risk of selection errors. The number of dispensing errors and near misses recorded for the pharmacy was very low as a result of this.

Each member of the team had an individual log-in for the PMR which provided an audit trail. The barcode on the product was scanned during dispensing and the system only printed off a dispensing label if the medication scanned was correct. A clear warning message was displayed on the screen if it was incorrect. NHS prescriptions were downloaded from the NHS spine and this information was used for dispensing which reduced the risk of a member of the pharmacy team entering incorrect information into the system. The SI regularly accessed management information that showed him the percentage of products scanned and the number of incorrect barcodes scanned. These checks showed him whether the pharmacy team were complying with the process and their dispensing accuracy. Both of these had key performance indicators (KPI's) attached and any issues were addressed. There were additional processes for split packs, packs without barcodes and certain medicines that the team had identified as high-risk.

Personal protective equipment (PPE) was available and was being worn by the pharmacy team. Workplace COVID risk assessments had been completed for employed members of the team. Pharmacy team members were asked to carry out lateral flow tests twice a week.

People could give feedback to the pharmacy team in several different ways; verbal, written and online. The pharmacy team tried to resolve issues that were within their control and the SI could contact the

person directly to discuss their complaint. There had been a complaint about a faulty injection needle and when the SI spoke with the patient, he identified that the fault had been a user error rather than a faulty device. He used this as a learning opportunity and amended the counselling information provided to people that were supplied with injectable weight loss medication. Some people had contacted the pharmacy to ask why they did not sign the dispensing label, which is traditional practice in a pharmacy, the SI explained to them that the quick reader (QR) code on the dispensing label could be scanned at the pharmacy to see exactly who had dispensed and clinically checked the prescription and when, and this information was also stored within the PMR.

People requesting weight-loss treatments were asked for consent to contact their usual GP surgery during the online questionnaire and again during the telephone consultation. A letter was sent to the persons' GP every time a person consented, however this rarely happened. The SI said that he had not been contacted by any healthcare professionals about private prescriptions he had issued. There are risks associated with not informing a person's usual prescriber that a GLP1-receptor agonist, such as Saxenda or Ozempic, has been prescribed and it was unclear whether the PIP explored this or explained the importance during telephone consultations. And the rationale for prescribing in the absence of consent was not made clear in the clinical notes.

The pharmacy and PIP had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was displayed in the dispensary and the RP log met requirements. Controlled drug (CD) registers were in order and a random check matched the balance recorded in the register. Delivery records were maintained electronically. Private prescription records were in order and held electronically. Clinical records, including reasons for not making a supply, were made on the prescribing system.

Confidential waste was stored separately from general waste and destroyed securely. The pharmacy team had their own NHS Smartcards and confirmed that passcodes were not shared. The NHS Data Security and Protection Toolkit submission had been completed earlier in the year and some SOPs had been updated as a result. The website contained details of the privacy policy. The pharmacy computer terminals, laptop and tablet devices were all password protected. Patient information was stored in an encrypted form and individual documents were also password protected. NHS Summary Care Records were occasionally accessed, and the record of consent being obtained was made on the notes section of the PMR.

The PIP had completed level three safeguarding training and the details of safeguarding bodies across the UK were available if the PIP required them. No formal safeguarding referrals had been made. Questions about a person’s mental health history were asked as part of the online questionnaire and discussed during telephone consultations. The PIP addressed mental health as part of a holistic approach to weight loss.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

A small and skilled workforce provides the pharmacy's services. There is a focus on continual learning and development by the pharmacist independent prescriber. The pharmacy's team members are enthusiastic about their roles and they work effectively together to achieve common goals.

### Inspector's evidence

The day-to-day pharmacy team comprised of the responsible pharmacist (RP), the pharmacist independent prescriber and a trainee dispensing assistant (TDA) who was also the delivery driver. There were two additional pharmacists that could be called upon when required. The TDA was enrolled and working through two accredited training courses: dispensing assistant and delivery driver. The TDA had been working at the pharmacy since November 2020 and explained that he was due an annual review in November 2021.

The SI had identified and recruited some additional pharmacist independent prescribers to provide contingency cover for absence. The SI had requested that the PIP who was due to cover his upcoming annual leave undertake some additional learning due to the nature of the medication being prescribed. The SI was intending to observe a number of consultations to ensure the PIP was competent and asked the required questions during telephone consultations and made sufficient clinical records before allowing them to work unsupervised.

The PIP maintained a portfolio of competence which contained details of the additional training that he had completed to support his prescribing. Various courses had been completed, together with ongoing self-directed learning on the types of weight-loss medication that he was prescribing. The PIP had carried out learning that supported his holistic approach to weight loss, and how it linked to long-term health benefits.

The pharmacy team worked well together during the inspection and were observed helping each other. The pharmacy team discussed their ideas and suggestions on an ongoing basis and changes to the processes had been made based as a result of this feedback. There was a whistleblowing policy, and the details were displayed on the back of the staff bathroom door. No targets were set for the team.

The SI was part of several WhatsApp groups for pharmacy contractors which provided a support network. Ideas, suggestions, questions and concerns were discussed. One of the ideas that the SI had put forward on a WhatsApp group which included the PMR developer had been voted as a good suggestion by other contractors and was due to be included on an upcoming update to the system.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are safe, secure and professional. They are suitable for the services provided.

### Inspector's evidence

The pharmacy offered its services via its website www.quickmeds.co.uk. The website contained details of the pharmacy such as, the GPhC voluntary logo, the premises address, services offered, the name of the superintendent (SI), complaints procedure and the company policies. People accessed the online prescribing service through the website, and, at the time of inspection, the website was compliant with the GPhC's requirements for website layout. Consultations were condition based and people could state a preference when they completed the online questionnaire. The website had been redesigned after feedback from the GPhC and MHRA.

The premises were smart in appearance and well maintained. Any maintenance issues were reported to local contractors. The premises were adequately organised for the services being provided and the dispensaries were adequate sizes for the services provided. An efficient workflow was seen to be in place and dispensing and checking activities took place in separate areas.

The pharmacy was clean and tidy with no slip or trip hazards evident. The pharmacy was cleaned by pharmacy staff on an ongoing basis and a contract cleaner came in regularly to undertake a more thorough clean. The sinks in the dispensary and staff areas had hot and cold running water, and hand towels and hand soap were available. The pharmacy had heating and air conditioning units. Lighting was adequate for the pharmacy services offered. Prepared medicines were held securely within the pharmacy premises.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy ensures its services are easily accessible. Its website provides helpful information about the prescribing service, and the prescriber provides additional counselling and advice. The pharmacy team manages the services effectively and it follows clear processes when prescribing and dispensing medicines. And they have audit trails in place for each medicine from source to supply. The pharmacy keeps records of the checks it makes to ensure medicines remain safe to use and fit for supply.

### Inspector's evidence

The pharmacy had an NHS distance selling contract, so members of the public did not access the pharmacy premises to collect their prescriptions. The NHS pharmacy services could be accessed via the telephone, website and e-mail. Whilst the NHS pharmacy services were available to people across the UK, there was very little demand outside of the West Midlands area.

The dispensing process had been designed using the in-built safety measures that the PMR system provided. The PMR system had been selected for these additional checks and the way that it helped the team to manage the workflow. Every prescription was clinically checked by a pharmacist before it was released for dispensing. The SOPs had been created to reflect the process that the team followed. The dispenser used a 'picking note' to gather the medication required in a basket, scanned the barcode on the picking note and then scanned the barcodes on each of the medicine boxes. The PRM system printed off medication labels if the item that had been scanned was correct, and a warning message was displayed if an item was incorrect. There were additional steps if the medicine was being supplied was not a full pack, it did not have a barcode, or was on a list of medicines that the team had identified as being 'high-risk' and required an additional check. Medicines were scanned again as they were put into the delivery bag as an additional check. Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. There was a quick reader (QR) code on the dispensing label and the computer system recorded which member of the team had been involved in each stage, so there was a dispensing audit trail for prescriptions. Repeat NHS prescription requests were made by the pharmacy team and there was an effective process in place for managing the process. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available.

Multi-compartment compliance packs were used to supply medicines for a small number of patients. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of supply. Each person had a record sheet to show what medication they were taking and when it should be packed. Notes about prescription changes and queries were kept on the PMR. A sample of a dispensed compliance pack that was waiting to be delivered was seen, however, it was not labelled with descriptions of medication and patient information leaflets (PILs) were missing. This was discussed and the team agreed that this was not best practice, and they would review their approach.

Local prescriptions were delivered by the dispensing assistant or one of the pharmacists. They used a delivery management system linked to a portable device (POD) to plan the most efficient route, track the driver (for queries) and provide proof of delivery. Other deliveries relating to the online prescribing

service, which were usually fridge lines, were sent using Royal Mail using a next day delivery service. The SI had researched packaging materials that were suitable for sending temperature sensitive products and had started to use smaller boxes as a result of customer feedback. The temperature controls had been validated in the summer by sending a test box containing the usual packing materials and a data logger to Scotland and back. This was being repeated in the winter, so that the packing materials could be tested in extreme weather conditions. Information was provided about how to dispose of needles safely and sharps containers were available.

The website offered treatments for a range conditions including erectile dysfunction, skincare and allergies, but most of the requests it received were for treatments for weight loss. The weight loss online questionnaire had been through several stages of development since the prescribing service had started and the questionnaire supported the PIP to make prescribing decisions. He used the information provided by the online questionnaire as a basis for the initial telephone conversation when supplying unlicensed medicines. The online questionnaire for weight loss was going through another stage of development to incorporate some additional questions that the PIP usually asked. The intention of the online questionnaire was to standardise the information provided by the patient and to form some of the clinical records for the service. The online questionnaire was completed in full for each future request so that the PIP could see the changes and he contacted the person if he wanted to ask them additional questions before issuing the next prescription. Some of the medicines that were available for weight loss were unlicensed for that indication. Information about what that meant was available on the pharmacy's website and was explained to the person during the telephone consultation.

During telephone consultations the PIP asked open questions about the persons weight loss journey so far and their experiences with other programmes or medication. The PIP asked about diet and exercise and tailored his advice based on what the person was already doing. For example, if someone already cycled or walked a lot, he would suggest exercise that involved other parts of the body and signposted people to a website that gave further information about healthy eating and an easy-to-follow full body exercise programme. The addition of a waist circumference measurement was a new question that had been recently been added to the online questionnaire. The PIP advised people with a certain waist measurement that they had a higher risk of cardiovascular disease and other conditions, due to their visceral fat and stressed the importance of adopting a healthy lifestyle in the long term and doing full body exercise to reduce visceral fat. People using the online prescribing service for weight loss medication were sent counselling information, including links to YouTube videos, and they could respond to the message with any questions they had. The PIP also sent healthy eating and lifestyle advice to people if weight loss medication was not suitable.

The PIP asked people about their mental health issues if the person felt comfortable in discussing it. He explained that mental health issues and weight were often linked so he liked to understand more so that he could tailor his counselling and safety netting accordingly. People that had previously been in abusive relationships came up a lot. If someone had a historical diagnosis of a mental health issue the PIP would ask about their coping strategies.

People receiving unlicensed weight loss medicines were titrated to the maximum dose depending on their tolerance. If the PIP suspected people were exceeding their dose he counselled them and refused future supplies.

The PIP identified several different reasons for stopping weight loss treatment, such as when a person’s target BMI was reached, the person had reached the maximum treatment length as documented in the treatment protocol, if weight loss plateaued or there was insufficient weight loss over a period of time. The PIP contacted the patient when a person was coming towards the end of their treatment programme to speak to them about how they were feeling about stopping treatment and provide

advice about how to maintain a healthy weight.

Medicines were stored in an organised manner on the dispensary shelves. Date checking took place regularly and no out of date medication was seen during the inspection. There was a date checking matrix available to record date checking. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Medicines were obtained from a range of licenced wholesalers and the pharmacy was alerted to drug recalls by PharmData and marked as actioned on that system. The CD cabinet was secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were usually working within the required temperature range of 2°C and 8°Celsius.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team uses the equipment in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the BNF. Internet access was available. Patient records were stored electronically and there were enough terminals for the workload currently undertaken. A range of clean, crown stamped measures were available. Screens were not visible to the public as members of the public were excluded from the premises.

## 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. |