General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: MY PHARMACY 365, 49-51 Crow Road, Glasgow, G11 7SH

Pharmacy reference: 9011356

Type of pharmacy: Internet / distance selling

Date of inspection: 07/08/2023

Pharmacy context

The pharmacy is in a medical aesthetics clinic in Glasgow. It is a private pharmacy and is closed to the public. People access the pharmacy's services through its website, https://mypharmacy365.co.uk by telephone or following a consultation at the clinic. The pharmacy's private prescribers, who are based in the clinic, prescribe for a limited range of treatments including for weight loss.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

The pharmacy adequately manages the risks with its online services. It has documented procedures for the prescribers and team members to follow to help make sure people receive medicines suitable for them to take. And it completes some reviews of the effectiveness of these procedures to help keep its services safe. The pharmacy keeps the records required by law and team members keep people's private information secure. It has adequate processes to help team members protect vulnerable adults and children.

Inspector's evidence

The pharmacy was in a private clinic that was registered with Healthcare Improvement Scotland (HIS). It provided a small range of prescription only medicines (POMs) including injectable medicines for weight loss and hormone replacement therapy (HRT). The responsible pharmacist (RP) had access to the consultation records of people requesting medication through its website. They also had access to prescriber notes to carry out the necessary clinical checks before making supplies. The pharmacy and the clinic staff worked closely together. And they had a systematic approach to risk assessment and risk management for prescribing services across the whole organisation. The pharmacy completed risk assessments for its prescribing services. And the individual risk assessments for each service followed a methodical and detailed template. The superintendent pharmacist (SI) and medical director reviewed the risk assessments on a regular basis. This included applying a scoring system to identify whether the risks were being adequately managed and the controls to manage them.

The pharmacy's prescribing policies considered prescribing within the manufacturer's licence and with reference to recognised national guidance. And team members were required to inform people's own doctor (GP) via email or post if they were prescribed specific medicines. The SI had completed a risk assessment following the clinic's proposal to prescribe specialist, controlled medicines for ADHD. And they had decided not to dispense these medicines due to the risks associated with record keeping and supply of these medicines. The SI demonstrated the system for receiving requests and generating prescriptions. Prescribers were able to contact people directly if more information was required to provide medication safely. Prescribers and pharmacists using the system could view records of both prescription-only-medicines (POMs) and pharmacy medicine (P-med) sales provided by the pharmacy. Records of any previously rejected requests were also visible. Team members had their own log on and password for the system, and access was limited dependent on their role.

The pharmacy used standard operating procedures (SOPs) to define the dispensing processes and governance arrangements. But team members did not routinely annotate them to show when they had read and understood them. The SOPs were available to read online, and hard copies were also kept in a folder in the dispensary. Some of the hard copy SOPs had not been reviewed since February 2020. This meant there was a risk that team members were not following current working practices. The pharmacy was in a private clinic and mostly operated between 16.00 and 18.00 hours. The trainee dispenser who also worked on the reception in the clinic knew not to commence dispensing tasks or any other regulated activities until the RP signed in.

Team members signed dispensing labels to show who had dispensed and who had checked

prescriptions. This meant there was an audit trail of who was involved in dispensing. It also helped the pharmacist to support the trainee dispenser to learn from their mistakes. Team members recorded their near miss errors. And they monitored them so they could discuss any patterns and trends that emerged. This helped to identify risks and implement improvements to manage dispensing risks. The SI reviewed the pharmacy's compliance with GPC premises standards. And a template form showed they had identified gaps and made improvements to keep services safe and effective. The pharmacy had not yet completed formal audits of prescribing activity due to the low levels of prescribing so far. But the SI explained they had planned audits such as reviewing the frequency of requests of higher-risk medicines and compliance with the pharmacy's prescribing policy policies. The clinic's prescribing policies required prescribers to peer-review a selection of each other's consultations to provide feedback and any learning points. The outcomes were discussed individually with each prescriber to help improve practice. The SI attended regular governance meetings and discussed changes and improvements with the medical directors.

The pharmacy trained its team members to handle complaints. And it provided contact details so that people could complain directly to the pharmacy or the relevant authority such as the General Pharmaceutical Council or Healthcare Improvement Scotland for its prescribing service. Team members knew to report dispensing mistakes that people reported after they left the pharmacy. And they contacted the SI to let them know. They carried out an investigation with the help of the clinic manager who was independent to the pharmacy. This helped to identify the root cause and any mitigations to improve safety arrangements. A recent incident involving the delivery to the wrong address was investigated with improvements made. The pharmacy and associated clinic received feedback through online feedback via known services such as Google and Trust pilot. The feedback had not been sufficient to make improvements or develop the services it provided. Someone who lived in a remote area that could only be accessed using a ferry service had contacted the pharmacy to ask for a treatment that required a cold chain delivery service. And following a risk assessment the SI identified that they were unable to provide the necessary assurances that the medication would be fit for purpose. This was due to potential ferry disruptions and other factors and they declined to make a supply.

Team members maintained the records they needed to by law. And the pharmacy had appropriate public liability and professional indemnity insurance policies in place which were valid until 23 January 2024. The pharmacy displayed a responsible pharmacist (RP) notice, and the RP record showed the time the pharmacist took charge of the pharmacy and the time they finished. Pharmacy team members received paper versions of prescriptions from prescribers working in the private clinic that they signed in ink. And it retained the original copy of these prescriptions for audit. A sample of these records were seen to be complete. The pharmacy was closed to the public and only authorised persons were granted access. A data protection policy was available for team members to refer to. And team members understood data protection requirements and how to protect people's privacy. They used a cross-cutting shredder to safely dispose of confidential information. Access to people's personal information was password protected. And each team member had their own personal log on credentials which were dependant on their roles and responsibilities. This ensured they only accessed relevant information to carry out the tasks they had been authorised to.

The pharmacy used identity checking software to check the details of people requesting medicines online. If the software identified a failure in the information submitted, the person would be required to submit further information including a photo with their ID for the pharmacy to verify. This provided assurance of people's details and identity. It also identified those entering false or fraudulent details. The pharmacy trained its team members to manage safeguarding concerns. And it provided a policy for them to refer to. This included contact details for the relevant agencies. Team members knew to speak to the pharmacist if they had cause for concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And the pharmacy supports its team members' ongoing learning and development needs. The pharmacy reviews its staffing levels in line with changing workload. And it has reliable plans in place to cover team members' absence.

Inspector's evidence

The pharmacy opened for around two hours each day which was mostly between 16.00 and 18.00. A pharmacist and a trainee dispenser worked together to provide the service, and this was sufficient to manage the current prescription workload. Three regular pharmacists provided cover when required. And the SI, who was contactable, supported the pharmacists in developing the necessary knowledge of online pharmacy operations for them to safely work there.

The clinic manager maintained a record of individual's professional registration. And they carried out regular checks to confirm that registration was still valid and up to date. The trainee dispenser worked in the pharmacy, and they also carried out reception duties in the clinic when the pharmacy was closed. The pharmacy provided protected time in the workplace, and this supported team members in completing qualification training coursework. The SI worked as a prescriber in primary care three to five days a week and this kept their prescribing knowledge up to date. The SI, the doctor and the lead nurse were medical directors. They met on a regular basis to collaborate and to make decisions affecting the pharmacy's operations.

Team members attended an annual appraisal of performance. This helped them to identify developmental needs to provide a safe and effective pharmacy service. The pharmacists coached the trainee dispenser to help them with qualification training. And they arranged mock scenarios to gather the necessary evidence to demonstrate competence with the required training standards. This was due to the specialist nature of the pharmacy's services. They also planned to deliver training with regards to some of the well-known high-risk medications that the pharmacy did not routinely supply. This included medications such as valproate, warfarin, and methotrexate. The SI encouraged team members to provide feedback and make suggestions for improvements. They understood their obligations to raise whistleblowing concerns if necessary. And they knew to refer concerns to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, hygienic, and secure. The pharmacy's website looks professional and provides ease of access for people to use. It is well-maintained and up to date and suitable for the services it provides.

Inspector's evidence

The pharmacy operated from within a private clinic building and a receptionist was on duty during opening hours. People could access private services online through the pharmacy's website which provided details about the owners, its physical location and contact details. It also provided the names and the registration details of the SI and the prescribing doctors. Prescribing consultations were undertaken via the company's website. The consultation was questionnaire based and avoided providing a negative answer to a question. This avoided directing people through the questionnaire to obtain a medication that was not suitable for them. The website was laid out in such a way that a prescription only medicine (POM) could not be selected before completing a consultation.

The pharmacy was located at the rear of the clinic building and it provided ample space for its services. It was well-organised and provided a series of shelves and bench space for dispensing. Team members kept the areas neat and tidy and free from congestion. All areas were organised and free from slips, trips and falls hazards. Consultation rooms were available. These provided suitable areas for activities that required extra safeguards to manage confidentiality. Team members used the dispensary sink for hand washing. And they cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has adequate safeguards in place to help ensure people receive medicines that are suitable for them to take. And it makes its services accessible to people. The pharmacy orders its medicines from reputable suppliers and stores them properly. Team members carry out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

People accessed the pharmacy's services via its website, and it provided information about its online prescribing service and how to use it. People could communicate with the pharmacy via the telephone or e-mail and contact details were provided. It also included information on the conditions and treatments available. The pharmacy had not promoted its website so had only received a small number of requests this way. People completed an online consultation questionnaire to access the pharmacy's private prescribing service, and the SI reviewed it. People requesting medication for weight loss were required to attend a face-to-face appointment at the clinic. This meant that weight loss injections were not prescribed remotely. Most prescriptions were for people who attended the associated private clinic. The RP had access to the prescribing consultation and the doctor's notes which they could refer to during checks.

Team members managed dispensing tasks well. They used dispensing baskets during the assembly and labelling process to keep items safely contained and to avoid the risk of items becoming mixed up. The pharmacy purchased medicines and medical devices from recognised suppliers and team members checked expiry dates and removed stock before they went out of date. Team members kept stock neat and tidy on a series of shelves. And they used a medical fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. The pharmacy supplied dispensed medication directly to the clinic. And it kept a record of when these were supplied, and which clinic team member had been responsible for storing them securely. Most people collected their medication from the clinic and some people received their medication by post. But this did not include items requiring cold chain delivery methods. The pharmacy used the postal service and a recognised courier for deliveries. And it was able to track supplies during the delivery process.

The pharmacy had a SOP that defined the procedure for patient safety and drug device alerts and team members carried out the necessary checks and knew to remove and quarantine affected stock. They also kept an audit trail to evidence the checks. This showed they had acted on an alert for Atomoxetine 40mg and 60mg capsules that was effective for July to September 2023. The pharmacy had medical waste bins. And this supported the pharmacy team in managing pharmaceutical waste which was collected for off-site destruction by an approved provider. The pharmacy did not supply valproate medication, but the SI planned to discuss the risks to the unborn child with the trainee dispenser.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources which included the electronic BNF. The pharmacy had password-protected computers. And confidential conversations could be carried out in private with people that contacted the pharmacy. The pharmacy used discreet packaging for deliveries. This meant that people were unable to identity the medicines that were contained within. The pharmacy used cleaning materials for hard surface and equipment cleaning.

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.