General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Click Pharmacy, Lower Ground Floor, 46 Woodgrange Road, London, E7 0QH

Pharmacy reference: 9011460

Type of pharmacy: Internet / distance selling

Date of inspection: 27/05/2021

Pharmacy context

This pharmacy is situated on a busy high street and serves a range of people. The pharmacy provides its services online, and members of the public cannot physically access the pharmacy. It dispenses prescription medicines and sells over-the-counter medicines to people accessing its services via the internet. It offers a prescribing service and dispenses private prescriptions generated by a pharmacist independent prescriber who works remotely. The pharmacy also provides a delivery service. This inspection was undertaken during the Covid-19 pandemic.

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 identify and manage all of the risks involved with its services. For example, it supplies some medicines for conditions which require ongoing monitoring and cannot demonstrate that it shares relevant information about the person's treatment with their regular GP. The pharmacy's risk assessments for the online prescribing service are brief, general and missing details. The pharmacy does not always follow through with the actions identified in its own risk assessments.
		1.2	Standard not met	The pharmacy does not carry out audits or reviews of its prescribing service. So, there may be associated risks that are not being properly identified and managed. And it makes it harder for the pharmacy to demonstrate that its services are safe and effective.
		1.6	Standard not met	The pharmacy does not routinely make records of any communication it has with people's GPs. So, it cannot demonstrate what was communicated, and cannot audit this activity. The pharmacy does not maintain a record of the reason for its prescribing decisions. And it does not maintain a full record of private prescriptions it dispenses.
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 prescription-only medicines before they have a consultation with a prescriber.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy cannot always demonstrate that it shares any relevant information about consultations or prescriptions with other healthcare professionals involved in people's care, including their GP. And it does not always follow the relevant guidance.
		4.3	Standard	The pharmacy does not always store its

Principle	Principle finding	Exception standard reference	Notable practice	Why
			not met	medicines securely. And it does not routinely date check its stock medicines. It doesn't keep all its medicines in appropriately labelled containers. So, there is a risk that people receive medicines that are past their expiry date. The pharmacy cannot sufficiently demonstrate that it disposes of its waste medicines safely.
5. Equipment and facilities	Standards not all met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not sufficiently identify and manage the risks associated with its online prescribing service. And it does not audit or review the safety and quality of its prescribing service. The pharmacy's record keeping is poor. However, it generally protects people's personal information adequately. And people can provide feedback about the pharmacy's services.

Inspector's evidence

The superintendent pharmacist (SI) said that some changes had been made in response to the Covid-19 pandemic. Fewer members of staff were working at the pharmacy and team members always wore face masks. The premises were cleaned by a cleaner, but the SI did not know how often this was as the cleaner worked outside the pharmacy's opening hours. Members of staff were not involved in other cleaning tasks, such as disinfecting worktops. The worktop was stained in some areas and the carpet was not clean. A Covid-19 staff risk assessment had not been carried out.

The pharmacy had carried out a risk assessment for services and medicines provided at a distance. But the risk assessment was short, brief and general and reviewed risks by condition and not by medication. There were details missing, for example, it stated that orlistat should be stopped after three months if there was no effective weight loss but did not stipulate what that amount of weight-loss should be. There were no automated flags on the dispensing system although the risk assessment mentioned these flags. This may mean that inappropriate supplies were not flagged up effectively. The risk assessment stated that prescribing was based on NICE guidelines, but this was not referenced in the risk assessments. The risk assessment also identified record keeping, for example the requirement to record complaints and refusals of medicines, but these actions had not been followed. The pharmacist independent prescriber (PIP) believed that the SI carried out prescribing reviews and audits, but the SI said that none had been done. And this means that the pharmacy did not monitor the safety and quality of its prescribing service. And may be missing out on opportunities to make this service safer, or to identify and manage any further risks associated with it.

Standard operating procedures (SOPs) were available at the pharmacy but the SOP dealing with absence of the responsible pharmacist (RP) was missing. The SI said she would implement this as soon as possible. SOPs were not signed by members of the team which may make it difficult to ascertain if they had read and understood them. The SOPs were last reviewed in September 2020 and the SI said they were reviewed annually.

The SI said that dispensing mistakes which were identified before the medicine was handed to a person (near misses) were recorded. Only one near miss, recorded in January 2021, was seen. Other records could not be found. The SI did not think there had been other near misses since January 2021. She said she tried to reflect on near misses and make changes to help reduce the risk of them happening again. But she could not remember any examples of changes that had been made. Boxes of different medicines and strengths were seen to be mixed in trays on the shelves. Although the SOPs stated that audits of near misses should be carried out, none had been done.

Incidents were recorded on an electronic risk log, but they were missing patient and prescriber details. There was very little information on contributory factors and learning points, for example, one entry stated 'always double check' as an action point.

A complaints procedure was in place and people were able to raise concerns via the pharmacy's website or by telephone. The SI discussed making changes following feedback, for example, medicines were now packaged better after some had been damaged in transit.

An in-date indemnity insurance certificate was not available on site. The SI sent a copy of the certificate following the inspection. Although all prescription-only medicines were only supplied via private prescriptions, a record of which prescriptions it had dispensed was not maintained. An electronic record of dispensed private prescriptions was not available on the dispensing software. So, the pharmacy may not be able to show which supply of medicines corresponded to which particular prescription. This may make it difficult to track and audit supplies. Emergency supplies, controlled drugs and unlicensed medicines were not provided from the pharmacy. A RP sign was not displayed and a correct one was printed out at the time of inspection. A sample of the RP record seen was in order. The pharmacy did not routinely make records of when any contact had been made with a person's GP. Occasionally the person's GP was emailed but retrieving these relied on the SI remembering if an email had been sent. The PIP did not keep records of the clinical justification for prescribing or refusal to supply and was not checking if the GP was contacted. And so, it was not possible for the pharmacy or PIP to check what had been communicated, or to easily audit this activity. This could also increase the risk of supplying medicines for conditions which require ongoing monitoring without the GP's knowledge. Doxycycline had been supplied without consent to share details with the person's GP. A person requesting a Ventolin inhaler and another requesting metronidazole had both given consent to share with their GPs, but the pharmacy had not kept records of communications made over the telephone with the GP.

The SI was not entirely sure how and if data was stored securely on the server but said that there was 'no way' the data could be compromised. Following the inspection, the SI sent additional information and said that the pharmacy had a dedicated private server which was only accessible to the director. The server was backed up every 24 hours and all the data was stored securely on cloud-based servers. The pharmacy was also registered with the Information Commissioners Office. Confidential information was shredded at the pharmacy. Computers were not password protected and other people (such as the cleaner and building receptionist) had access to the premises. The SI said she would ask the cleaner to work during the pharmacy's opening hours and create a password for the computer. Members of the team had not completed training on information governance or the General Data Protection Regulation.

The SI had completed a module on safeguarding vulnerable groups from the Centre of Pharmacy Postgraduate Education (CPPE). The assistant had not yet received any training. The SI said she would contact the relevant bodies if she had any safeguarding concerns. When asked about how she obtain the relevant contact details, she said she would check the CPPE training module which could cause additional delays in obtaining this information. The SI said she would complete refresher training and ensure that the assistant also completed the relevant training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides. Members of the team do some training. But they don't always do regular ongoing training, so it may make it harder for them to keep their skills and knowledge up to date. The pharmacy does not have a robust contingency plan in place. So, it may be harder for it to ensure the continuity of its services in an emergency.

Inspector's evidence

All pharmacy shifts were covered by the SI and an assistant, who were both present during the inspection. The assistant was involved in logistical and administrative tasks, such as packing orders and processing orders of General Sales List medicines received via an online retailer. She was not involved in dispensing prescription-only medicines and said she would not carry out any tasks if the SI was not at the pharmacy.

The pharmacy did not have a robust contingency plan in place. The SI said that the pharmacy would not open if she did not attend work. When asked about how next-day delivery orders would be processed if this happened, the SI said she would contact another assistant to cancel the order and contact the customer. However, this assistant was currently abroad, and had been there for several months due to the pandemic. The SI said she would review the pharmacy's business continuity plan.

The SI said that she had not completed any training recently but read emails from a pharmacy magazine. She also completed CPPE modules but had not done any for some time now. Training records were not maintained at the pharmacy. The assistant had been briefed about processes at the pharmacy, but she had not read the relevant SOPs and was not provided with ongoing training. Targets were not set for the team. The assistant reported that she felt comfortable to approach the SI and owner with any issues regarding service provision.

During a telephone conversation, the PIP said he worked in a GP practice and only prescribed medicines at this pharmacy for conditions that he had been trained on at the GP practice. In addition to continuing professional development, he had completed development work in general practice and a level six responding to minor illnesses course. He added that he prescribed within his own clinical competence and ensured he was up to date with all medicines provided at the pharmacy. He would refer people to their GP if he was unsure. He had not had any performance reviews at the pharmacy and said he was happy to communicate with the pharmacy team if he was not comfortable prescribing a medicine. The prescriber said he provided feedback and input regarding the pharmacy's SOPs, which were written by the SI.

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

Summary findings

The pharmacy's website allows people to choose a prescription-only medicine before beginning a consultation with a prescriber. This could mean that they may not receive the most suitable treatment option for their needs. The pharmacy provides an adequate environment to deliver it services from. But it could do more to keep its premises clean and organised.

Inspector's evidence

The pharmacy was located in the basement of a building and was accessed through a manned reception desk. The pharmacy was spacious but it was disorganised. Boxes, tubs and other items were stored untidily, the carpet was littered with small pieces of paper and medicines were stored in a disorganised manner. Some boxes were stored on the floor which presented tripping hazards for the team and some areas of the worktop were stained.

The temperature was suitable for the storage of medicines and there was enough lighting throughout the dispensary. The pharmacy was kept secure overnight.

The pharmacy's website outlined the required information, such as the pharmacy's GPhC registration number, the name of the superintendent pharmacist, and the name and physical address of the registered pharmacy that supplied the medicines. However, people accessing the website were able to select a prescription-only medicine before having a consultation. And although this had been discussed with the SI and owner previously, remedial action had not been taken.

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

Summary findings

The pharmacy does not always provide its services safely. It cannot always demonstrate that it shares details of supplies made with peoples' GPs or signposts to other services appropriately. It does not maintain clear audit trails between the prescriber, GP and pharmacist which may mean that important information is not accessible to the relevant people. The pharmacy gets medicines from licensed suppliers, but it doesn't store them securely or routinely date check its stock medicines. This increases the risk that people may get medicines that are not suitable to use. The pharmacy cannot demonstrate that it disposes of its waste medicines safely. However, the pharmacy's services are accessible to people. The pharmacy reacts appropriately to medicine safety alerts. But it does not always keep records of what action it has taken. So, it may be harder for it to show what it had done in response.

Inspector's evidence

Services were advertised on the pharmacy's website. People were able to contact the pharmacy via the website, email or telephone. The pharmacy's opening hours were listed as 9am to 6pm but the SI said she normally worked from 11am. The telephone line did not work if the SI was not in, which may mean that people could not access the pharmacy for advice, even within opening hours. The SI said that she would in future direct calls to her telephone if she started late.

The SI said that dispensing audit trails were maintained using the 'dispensed-by' and 'checked-by' boxes on the medicine labels. There were no prescriptions to prepare at the time of inspection so this could not be verified. The SI said that the assistant conducted an administrative check before packing the medicines. Medicines were delivered by the Royal Mail using a signed-for service. The SI said that there had been several missing deliveries, but these were not documented at the pharmacy. People were either refunded their money or sent replacement medicine.

The pharmacy mainly dispensed antibiotics, sumatriptan, norethisterone, medroxyprogesterone, sildenafil and nasal sprays. Over-the-counter products supplied included triamcinolone nasal spray, antihistamine tablets, skincare products for dry skin and mouthwash. A UK-based PIP prescribed for people accessing the pharmacy's services.

Online questionnaires completed by people were first sent to the SI for pre-screening. She contacted the person if necessary, for example, if the person's GP details were missing. Consent to share details with the person's GP was only requested for antibiotics and inhalers. The PIP said that he was not involved in obtaining consent to share details with the GP and that this was normally done by the SI. The pharmacy was not able to demonstrate that the patient's GP was contacted when a supply was made for conditions requiring ongoing monitoring, such as asthma inhalers. And the PIP did not keep clear records of the clinical justification for prescribing or refusal to supply. An order for doxycycline was seen to have been approved without consent to share the details with the person's GP. And, although consent to share with the person's GP had been provided by a person requesting a Ventolin inhaler, there were no records found about any communication with the GP. The SI said that this was done by telephone, but it was not documented.

The prescribing policy stated that only one Ventolin inhaler should be supplied every two months, but during a telephone conversation, the PIP stated that only two inhalers would be supplied every six months. This could mean that inappropriate supplies were not flagged up in line with the pharmacy's

prescribing policy. Ventolin was not included in the pharmacy's risk assessment for the prescribing service, but a separate SOP was available for its supply. A range of antibiotics were prescribed, including some for sexually transmitted diseases. But there was no link to local prescribing policies or sexual health clinic guidance in areas the pharmacy covered. For example, a person had been prescribed azithromycin because their partner has tested positive for Chlamydia. The pharmacy had not followed good practice guidance such as the British Association for Sexual Health and HIV guidance which recommended screening and had just offered treatment to the person.

Questionnaires people had filled in online were sent electronically to the prescriber for approval. The PIP said that he checked a person's medical and order history. Symptoms were assessed using template questions and free-type boxes for people to include additional information. Certain medicines, such as opioids, were not prescribed. The PIP said that he spoke to the SI if he had any queries. Communications between the SI and PIP were not routinely documented unless they were done by email. The system was updated once an order had been approved or rejected. Refusals to supply were not always documented clearly, unless communication was made by email. For example, the SI said that a request for lansoprazole had been declined due to patient age, but this was not documented anywhere. The PIP did not keep records of any clinical decisions made, any reasons for refusal or if GP consent had been obtained.

Repeat orders and the maximum quantity of a medicine which could be supplied were not flagged up automatically on the system and had to be checked manually. The SI believed that the maximum number of supplies of metronidazole and nitrofurantoin were three to four times. And said that if the infection returned within a short period of time then the person would be referred to their GP. The SI could recall an incident where a GP had communicated to state that supply of metronidazole was inappropriate for a particular person, but the SI could not find a record about this communication. Evidence of the email communication between the GP and the SI was sent to the inspector following the inspection, but this relied on the SI's recollection of the communication as it had not otherwise been documented. The SI also stated that there were incidences where people had provided incorrect details of their GP practice. These had been discovered when the pharmacy had contacted the GP practices but by this point an antibiotic had been supplied. No records of this were kept and the SI relied on remembering peoples' names. The PIP said he used NICE guidance when prescribing antibiotics. He was not an antimicrobial guardian but said he had completed a CPD cycle on antimicrobials.

Identity checks were only made for inhaler requests. An online, third-party risk-based system was used to confirm the person's details matched those provided to the pharmacy. The SI contacted the person if they did not pass the ID check. She said that records of additional checks made were maintained but these could not be found during the inspection. No identity checks were made for medicines other than inhalers. So, this makes it harder for the pharmacy to know who it is prescribing for or supplying the medicine to.

The SI said that she checked the expiry dates of medicines when dispensing. Regular expiry date checks for dispensary stock were not conducted or documented. Several loose blisters, some missing batch numbers and expiry dates were found on the shelves. And this meant that it may not be possible to check the expiry dates for these medicines before they were supplied. Drug alerts and recalls were received electronically. The SI said that alerts were actioned and the stock at the pharmacy was checked. But records of any action taken in response to these were not maintained. Returned or date-expired medicines were kept separate to stock, in a box. The SI said that these medicines were taken to another pharmacy for disposal as this pharmacy did not have a contract with a licensed waste carrier. It was not clear which other pharmacy the SI referred to, as there were no other pharmacies owned by the company. And so, it could not be sufficiently demonstrated that the pharmacy's waste medicines

were disposed of safely. Medicines were also accessible to the cleaner, who accessed the premises outside the pharmacy's opening hours.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

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

Inspector's evidence

The pharmacy team had access to up-to-date reference material. Computers were not password protected but the SI said she would ensure that this was done. The shredder was in good working order.

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.