

Registered pharmacy inspection report

Pharmacy Name: MedExpress Pharmacy, Unit 7B, Datapoint, Cody Road, London, E16 4TL

Pharmacy reference: 9011509

Type of pharmacy: Internet

Date of inspection: 15/09/2023

Pharmacy context

This is a distance-selling pharmacy (www.medexpress.co.uk) linked to an online prescribing service. The pharmacy only dispenses private prescriptions, generated by a team of pharmacist independent prescribers. Medicines are delivered via courier to people living in the UK and EU. The types of medicines mainly dispensed are for conditions such as erectile dysfunction, weight management, hair loss, migraine and asthma. The pharmacy is closed to the public and situated in a serviced warehouse.

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

The pharmacy identifies and manages the risks associated with its online prescribing service. It has documented procedures for team members to follow to help make sure people receive medicines suitable for them to take. And it completes regular reviews of the effectiveness of its risk assessments 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 had a set of written standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. Team members described their roles within the pharmacy and the processes they were involved in. They separated the role of selecting the medication and applying the dispensing label so that two team members were involved in process to help prevent the chance of error. Pharmacists carried out a final accuracy check.

The pharmacy's private prescribing services were led by a small team of pharmacist independent prescribers (PIPs). The pharmacy completed risk assessments (RA) to identify and manage the risk of providing services online and defined the control measures in place to mitigate these risks. A sample of risk assessments were seen by inspectors.

The risk assessment for each service followed a methodical template. They considered the risks around providing the service with reference to accessing people's records and the information provided by people on the consultation form. And contained information to be used when prescribing. They contained clinical guidelines to consider when treatment would not be appropriate. These were informed by UK national guidance such as the National Institute for Health and Care Excellence (NICE) along with the Summary of Product Characteristics (SmPC). The team carried out annual reviews of the risk assessments or reviewed them earlier if prompted by a service change, such as the introduction of a new medicine. RA's specified limits to specific quantities of medicines, or how often they could be supplied. For example, the pharmacy limited the supply of salbutamol or Ventolin to two inhalers every 180 days. And the pharmacy had incorporated these limits into the prescribing software to automatically highlight potential inappropriate requests to the prescribers. The pharmacy had identified that conditions such as asthma and treatment of urinary-tract infections were higher-risk. And had put extra safeguards in place to mitigate these risks, such as a mandatory requirement to obtain people's GPs details so it could inform them of ongoing treatment by the pharmacy. And if people with asthma were not reviewed by their own GP within twelve months, people would be asked to complete an asthma control test with a member of the pharmacy team. This assessment helped ensure people with uncontrolled asthma were not continuing to receive treatment inappropriate and referred to their GP. The pharmacy would not supply further inhalers if people's asthma symptoms were not controlled effectively. The consultation did not gather information on whether people were also taking inhaled corticosteroids to control their asthma. Inhaled corticosteroids are routinely required for the management of asthma and salbutamol or Ventolin are used as relievers for symptom control. It would be typical to expect that people requesting reliever inhalers would also be using an inhaled corticosteroid. So, the pharmacy could be missing the opportunity to gain further information on a long-term condition that may help aid the PIPs decision making. There was evidence of prescription

requests being put on hold until an asthma assessment was completed. And examples when the pharmacy team contacted people who had not supplied their GP details after the first supply to obtain this information before the PIPs issued a further prescription.

The pharmacy had processes to review the quality of the prescribing service it provided. The clinical governance team consisted of the superintendent pharmacist (SI), pharmacy lead pharmacist and PIPs. It met monthly and it documented the outcomes from the meetings. Regular audits were conducted to ensure that the prescribing safeguards in place were effective. The SI had completed an audit of higher-risk medication being prescribed. They looked at clinical and non-clinical reasons prescriptions were rejected. And reviewed a sample of prescribing consultations to determine whether decisions were appropriate. But this was for a small sample of prescriptions in comparison to the consultations carried out. Outcomes of the audit were fed back to wider prescribing team as well as the individual PIP. The pharmacy also had automated audit processes in place to review people requesting medication who had similar names or addresses.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as 'near misses.' And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. The pharmacy had a complaints procedure displayed on their website and welcomed feedback from a variety of sources including TrustPilot, satisfaction surveys, email, and phone. The pharmacy trained its customer service team members to manage complaints. And they knew how to escalate the complaint or query as required to the appropriate person.

The pharmacy had current indemnity insurance. The pharmacy also made a small number of supplies to people in the EU. The SI and PIPs had not considered the implications for prescribing and supplying medication to people outside the UK. Following the inspection, the SI provided assurances that the pharmacy's indemnity insurance covered these activities. And that they had assessed the legal requirements for prescribing the limited range of medicines that they supplied to people in these countries.

The pharmacy displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. The pharmacy recorded private prescriptions dispensed using a bespoke labelling system of its own design. From the records seen, it had accurate private prescription records. Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure destruction and computers were accessed via individual usernames and passwords. Team members were provided with training on protecting people's confidentiality and were asked to sign confidentiality agreements at the start of their employment. An information governance policy was in place and accessible to team members. Team members had been trained on safeguarding vulnerable groups. The contact details of local safeguarding teams were displayed in the pharmacy. The pharmacy did not prescribe for anyone under the age of 18. And it used a recognised identification verification system to check people's details were entered correctly.

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 team members' ongoing learning and development needs. The pharmacy provides team members with the opportunity to provide regular feedback. And they can suggest improvements to keep pharmacy services safe and effective.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, nine dispensing assistants, one of whom was the dispensary manager, four customer service team members and the SI. They were managed by the pharmacy lead. It employed locum pharmacist to provide cover as required. On a typical day, the pharmacy employed one pharmacist and six dispensing assistants. The pharmacy displayed team member's certificates of qualification. Team members were seen to be managing the workload. Team members spoken to during the inspection were experienced in their roles. The pharmacy reviewed staffing levels regularly. It used rotas to manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. The dispensary manager held daily team meetings to delegate set tasks to team members daily to ensure the pharmacy operated safely. They also held monthly dispensary team meetings to allow discussion around patient safety and operational issues. Team members received planned learning time during the working day to undertake regular training and development. And team members undertaking accredited courses were provided additional time to complete coursework. A trainee dispenser was observed being supervised in their role and described the training plan that they were working through. Team members had six-monthly appraisals with the dispensary manager to identify their learning needs.

The prescribing team worked remotely and consisted of one full-time PIP and three PIPs who worked on a part-time basis. Usually, two PIPs worked each day. They were supported by the SI when needed. PIPs were contactable should the RP or wider pharmacy team need to contact them. The PIPs had previous experience of working different settings such as general practice. Prescriber induction training was provided by MedExpress on all the medications prescribed, patient questionnaires and consultation information. The SI held regular appraisals with PIPs, reviewed their ongoing competency to prescribe and measured this against a set competency framework. The SI carried out a review of all PIPs training and competence in the last two months. This resulted in each PIP creating a portfolio which detailed their competence in each prescribing area, evidence of ongoing, relevant training, revalidation in line with the regulators requirements, and an annual declaration of having reviewed the pharmacy's risk assessments and prescribing policies. This ensured that the SI had appropriate oversight of the PIPs and that the PIPs practice remained up to date. PIPs used web-based communication software to engage with each other and discuss clinical queries. This allowed prescribers to seek advice and support from one another and facilitated shared learning. There appeared to be a culture where colleagues could seek advice from each other and ask questions if they needed help. And PIPs only reviewed consultations they felt competent to manage. The SI was able to show documented evidence of clinical queries that had been raised with the prescribers for advice and guidance by pharmacy team members. The PIPs also had access to a medical doctor for medical-related queries who also supported the pharmacy if they needed advice with regards to the provision of clinical services. PIPs had to be approved on all the consultations before they were able to prescribe during their induction training.

Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. They felt able to make suggestions and raise concerns to the pharmacist or dispensary manager.

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.

Inspector's evidence

People accessed private services online through the pharmacy's website. And it 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 pharmacists. Prescribing consultations were undertaken via the company's website. The website's layout was clear. It provided information on treatments, and consultations were started from the page for a particular medical condition. But it relied upon questionnaire-styled consultations which provided negative responses when an inappropriate answer is given. To help mitigate this risk, the system recorded if people made any changes to their answers on the form. The PIP could view changes made by people and it was automatically flagged to be considered as part of the consultation review.

The pharmacy was not accessible to members of the public. It was located within a large warehouse which was split into two units, housing two pharmacies. This pharmacy was located on the first floor. A reception area was located on the ground floor. The pharmacy was well organised. There were separate areas for processing and labelling prescriptions, packing and assembling medicines, checking, and dispatch. The pharmacy premises were clean and organised with sufficient work and storage space. Workbenches were generally kept clutter free. There were adequate hygiene and handwashing facilities for staff. The room temperature and lighting were adequate for the provision of pharmacy services. The pharmacy was secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has sufficient safeguards in place to help ensure people receive medicines that are suitable for them to take. And it makes its services accessible to people through its website. The pharmacy orders its medicines from reputable suppliers and stores them properly.

Inspector's evidence

The pharmacy used proprietary software for managing the process of prescribing and dispensing. When the PIP generated a prescription, the system logged the name of the prescriber, and it was date and time stamped to provide a complete audit trail. The software clearly identified who was responsible for reviewing prescription requests and who had issued the prescription. The prescriber added notes of any advice given on a consultation notes section on the system. But this was not recorded for every prescription and usually only completed when a prescription was rejected. When the PIP created a new prescription, they used pre-defined doses identified in the risk assessments. So, team members did not need to input directions when creating the labels. The prescriber was able to demonstrate how they reviewed a consultation on the platform. They accessed a list of medication requests, and reviewed the information submitted by a person online. The software highlighted issues for consideration by the PIP such as unexpected values relating to weight loss, or medication requested too early. And the system prevented a prescription being authorised if certain criteria had not been met. For example, if a prescription item was requested earlier than the pre-defined frequency. The PIPs asked the pharmacy team to contact people when appropriate. For example, to discuss medication requests, confirm information entered or changed during the consultation, or to gain further information. Team members then added this information to people's records which was reviewed again by the PIP. PIPs would only contact people directly to discuss specific counselling or clinical information with people relating to their health condition. They approved the prescriptions once they were satisfied that they were safe and appropriate. Multiple examples were seen where the PIPs had put prescription requests on hold until further information was obtained from the person requesting medication. This included consultations where the system identified information provided by the person differed to their last consultation. Examples of completed asthma control tests were seen. And team members demonstrated how they printed letters daily to be sent for communication to people's regular GPs by post.

Pharmacy team members followed a logical and methodical workflow for dispensing. They created dispensing labels using the electronic prescription after it was authorised by the PIP. Another team member used the dispensing labels to collect stock. They used baskets to separate people's medicines. The medicine was labelled and added to the basket with a shipping label. And they supplied patient information leaflets in alternative languages when required. The pharmacist undertook the final accuracy check against the dispensing label. But they had limited access to people's records to do this and were reliant on the software highlighting any inappropriate requests, for example, items ordered too frequently. So, there was little evidence of interventions by the RP.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines

and those inspected were found to be in date. The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records about what it had done.

Medication was delivered using a Royal Mail tracked service. The pharmacy mainly supplied medication to people in the UK. Any medication that was not successfully delivered was returned to the pharmacy. The pharmacy maintained a record of medication returned before destroying the medication. The pharmacy team could access this record if people raised a concern regarding failed delivery or requested a further prescription.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources. And separate private offices were used to hold confidential discussions with people that contacted the pharmacy. The pharmacy provided medication in original packs or manufacturers blister packs and did not require tablet counting equipment or equipment to measure liquids.

The pharmacy used discreet packaging for deliveries to help protect people's confidentiality.

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.