General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chemist4U, 34a-37 Greenhey Place, Skelmersdale, Lancashire, WN8 9SA

Pharmacy reference: 9011784

Type of pharmacy: Internet / distance selling

Date of inspection: 21/03/2024

Pharmacy context

This is an online pharmacy which people can access through the pharmacy's website or mobile application. It is situated in an industrial estate in Skelmersdale, West Lancashire. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines through its website. It also dispenses prescriptions for a variety of services, including NHS contracted services, weight loss services, and for medicines prescribed by its in-house prescribing service. Most of the medicines it supplies are delivered using a national courier. This was a targeted inspection specifically looking at how the pharmacy prescribed and supplied weight loss medicines. Weight loss medicines supplied against prescriptions issued by NHS contracted services, or CQC registered services, were not reviewed.

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 uses written procedures to help make sure its services are provided effectively. It records and investigates when things go wrong to help identify learning. Members of the team keep the records that are needed by law. And they are given training so that they know how to keep private information safe. When the pharmacy prescribes weight-loss treatments it also sometimes prescribes other medicines to treat side-effects they may cause. But it does not have a clear policy about how or when these medicines should be prescribed. And the prescribers cannot show whether they are taking enough care to make sure the symptoms they are treating are side-effects and not more serious health conditions.

Inspector's evidence

The pharmacy had written procedures for its services, contained within the pharmacy's standard operating procedures (SOPs). These had been recently issued in January 2023, and had a stated date of review in January 2025. SOPs were available through an electronic software portal, which recorded when people had read and accepted the SOPs. There were specific SOPs for the pharmacy's prescribing service and the associated websites.

A risk assessment had been completed for the provision of weight loss services. There was also a risk assessment for the medicines offered by prescribers. One of the risks that had been identified was that people may provide false information to obtain medicines. To address this risk a policy had been put in place for the prescriber to search for the person's National Care Record Service (NCRS). But it was unclear what would happen when NCRS access was not available or was missing information for the person. The risk assessment described the current controls as adequate, but there had been no supporting review or audit. So the pharmacy could not show whether it was effectively managing the risks it had identified.

The pharmacy offered a weight-loss prescribing service, which could be accessed via the pharmacy 'my-bmi' website. The service was provided by pharmacist independent prescribers (PIPs). People using the service could indicate if they were experiencing side-effects to their medication. To help manage any side-effects people were experiencing, the PIPs sometimes prescribed adjuvant medication, for acid reflux, sickness, or constipation. The clinical lead explained that the PIP would contact the patient to ensure the treatment was suitable before prescribing it. And as part of the conversation, they would conduct a full consultation. But there were no prescribing policies or risk assessments covering these medicines. And the records made by the PIP were limited to the side-effect, and the treatment. So it was not clear whether the PIP had checked for red flags or explored an alternative diagnosis. And there was a risk key symptoms for serious illnesses could be overlooked and not fully investigated.

Before any medicines ordered through the pharmacy's website were processed, the website automatically completed a number of checks to help identify any requests which may be inappropriate. The ingredients of the medicine were checked against previous orders to see whether medicines were being re-ordered too soon, or if there were any medicines which should not be taken together. And there was a system check for other accounts on the website to see whether a person was trying to circumvent the restrictions in place. Lexis Nexis was used to check the identity of anyone who requested prescription only medicines.

The pharmacy carried out a quarterly 'global audit' for all aspects of the business. Part of the document included audits completed on items prescribed by their in-house prescribers. These audits were completed by the clinical lead who would check 15 consultation records each quarter, compare whether the consultation was in-line with the pharmacy's procedures and whether the correct clinical advice had been provided. In the last audit, all prescribers had been found to achieve 100% compliance with the company's guidance and SOP. It also recorded what 'corrective and preventative actions' (CAPAs) had been completed following a reported incident.

The pharmacy kept records of errors and their learning outcomes. All incidents were recorded on electronic software and reviewed at the end of each month. Any learning identified within the monthly review was shared during team meetings. To help prevent dispensing errors involving incorrect quantities, team members in the dispensary had been asked to re-read one of the SOPs. A 'corrective and preventative action' (CAPA) investigation was used for any errors relating to the prescribing service. Examples of CAPAs were available and showed the learning which had been identified.

The roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The correct responsible pharmacist (RP) notice was displayed on the website. The pharmacy had a complaints procedure, which was available to read on the pharmacy's website. Any complaints would be recorded and followed up by senior management. A current certificate of professional indemnity insurance was seen. Records for private prescriptions, RP, and controlled drugs appeared to be in order.

An information governance (IG) policy was available, and this had been read by members of the team. Confidential waste was separated and removed by an authorised waste carrier. The pharmacy's privacy notice was available on its website and described how it handled and stored people's information. Safeguarding procedures were included in the SOPs. Registered members of the team had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said she would initially report any concerns to her line manager or the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough members of the team to manage the pharmacy's workload and they are suitably trained for the jobs they do. Members of the pharmacy team complete additional training to help them keep their knowledge up to date. Prescribers for the pharmacy's weight loss service receive specific training and review during their induction to provide assurance that they have the necessary competence.

Inspector's evidence

The pharmacy employed around 160 people across a number of departments. Of this number, 75 were pharmacy trained at different qualification levels. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed effectively. Staffing levels were maintained by part-time staff and a staggered holiday system.

The pharmacy's prescribing service had a clinical lead, who was a PIP and the line manager for its team of PIPs. New PIPs would undergo an induction programme. This included reading and familiarising themselves with the pharmacy's in house protocols, shadowing of their work by the clinical lead, completion of any training courses, such as a GLP-1 weight loss course, submission and review of their prescribing formulary, and assessment through the pharmacy's prescribing audit. All counselling and intervention were recorded on the pharmacy's software, which helped to provide a continuity of care across different prescribers. This also included when the pharmacist rejected a request for a prescription.

There was a monthly meeting which all team members were invited to attend. Smaller teams would also have more frequent huddles to discuss any ongoing work or to share learning. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to their line manager or SI. There were no professional based targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. Information on the pharmacy's website helps to inform people about who are providing the services.

Inspector's evidence

The pharmacy was located within an industrial unit and was suitable for the services provided. The pharmacy was clean and tidy. Team members were responsible for keeping each of the dispensing stations clean and tidy. The temperature in the pharmacy was controlled by air conditioning units and lighting was sufficient. The premises were maintained in an adequate state of repair. The pharmacy team had use of a staff area and several WCs with hand wash basins and antibacterial hand wash.

The pharmacy website contained details about who owned the pharmacy, its location, and contact details. The webpage showing who the current RP was also provided further information about who regulated the pharmacy. Part of the pharmacy's website was an 'Online Clinic'. This included details about the prescribers. People could commence a consultation from a conditions page, and it was clear that the final treatment choice would be decided by the prescriber. The pharmacy also worked with the website 'my-bmi.co.uk' by providing prescribing and dispensing services for consultations started through these websites.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible. And it manages and provides its weight loss services safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

Inspector's evidence

The pharmacy's services could be accessed via its website www.chemist-4-u.com, as well as associated websites. People could also contact the pharmacy via email, WhatsApp, Twitter, and live chat. It also had its own branded mobile phone app which included a messaging function. The pharmacy website included an 'ask the pharmacist' function, which sent messages directly to one of the pharmacists, so that they could respond.

The pharmacy's in-house prescribing service operated via the pharmacy's 'clinic' on its website and also the website www.my-bmi.co.uk. For each of the websites people would select a condition before starting a questionnaire-styled consultation. The questions were designed to help the prescriber understand the person's medical history and determine whether prescribing a medicine would be appropriate. Some of the questions were open-ended, meaning people could type an explanation into a box. For some of the closed 'yes or no' styled questions which were important clinical or safety questions, a negative response would appear if they were not suitable for the medication. The prescriber could see if a person had changed the response to an answer. The prescribers had used this functionality to contact the person and check their medical history further.

It was a requirement for people to provide consent for the pharmacy to access NCRS for each consultation. The PIP would review the answers provided as part of the questionnaire against the NCRS to ensure a full medical history was gathered. As part of the NCRS check, the pharmacy would use the recorded weight and compare it with the details submitted in the questionnaire. The PIP would also check for any red-flag conditions, such as eating disorders, pancreatitis, or severe heart failure. If the person did not have an NCRS, for example if they lived in Scotland or Wales, the PIP would place the consultation on hold until a printout of their record was received from the person's GP surgery. Or if there was no recent weight recorded on the NCRS, they would ask the person to visit their GP to record their latest weight which would update the NCRS record. But for those who did not have NCRS access, the pharmacy relied upon a person submitting a photo of them on their scales. So in these cases the pharmacy may not always have sufficient evidence to support its prescribing decisions. The clinical lead explained that they would usually re-check a person's NCRS at least once every three months. But there was no set process for this, and it had not been audited to check how often a PIP was rechecking NCRS. So any changes to a person's health may not be promptly captured.

It was also a requirement for people to provide consent for the pharmacy to contact their GP surgery following the issuing of a prescription and supply of medication. The pharmacy relied on the reaction to these letters for any people who may have avoided the safeguards in place. If the pharmacy received a notification from a GP surgery that the use of weight loss medication was not suitable for a particular patient, they would suspend that person's account. The pharmacy would only begin prescribing weight loss medicines again if they received evidence which showed it was appropriate to do so.

The clinical lead estimated that 50% of all orders were placed on hold whilst awaiting further

information. For example, verification of a person's weight, or when additional information was required such as for people who were restarting the medication after a gap in their treatment. A number of people had their orders declined because contraindications had been identified on the person's NCRS, such as gallstones, low BMI, or eating disorders. In which case, the pharmacy provided further explanation and referred them to other healthcare provides, such as their GP. People could remain on weight loss treatment as long as they did not develop severe side-effects, continued to achieve a 5% weight loss over a six-month period, and did not lower their BMI below 21.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used plastic trays to separate individual patients' prescriptions to avoid items being mixed up.

Medicines were sent to people using various Royal Mail services. Refrigerated items were packed inside special packaging which helped to keep the medicines at the correct temperature for up to 48 hours. The pharmacy had completed validation tests in Summer and Winter to check the packaging functioned correctly.

Medicines were obtained from licensed wholesalers. Medicines were date checked once every three months. A date checking matrix was signed by staff as a record of what had been checked, and a diary was used to remove the medicine at the start of the month of expiry. Controlled drugs were stored appropriately. Numerous fridges were situated within the pharmacy. All were equipment with a digital thermometer recording system. A remote alert system informed a list of senior team members if the temperature went out of range. Drug alerts were received by email through electronic software. Details of any action taken, by whom and when were recorded. In the event of a side-effect being reported from people taking newly licensed medicines, such as weight loss medication, the pharmacy would submit a yellow card to report it to the MHRA. A spreadsheet contained details of submitted yellow cards, and reference numbers, as a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

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.