

Registered pharmacy inspection report

Pharmacy Name: My Pharmacy, Hesketh House, 1a Hesketh Street,
Great Harwood, Blackburn, Lancashire, BB6 7DW

Pharmacy reference: 9011853

Type of pharmacy: Internet / distance selling

Date of inspection: 29/09/2023

Pharmacy context

This is a distance selling pharmacy located in the town of Great Harwood, Lancashire. The pharmacy dispenses both NHS and private prescriptions. It dispenses medicines for its private online prescribing service, which offers treatments for various conditions such as asthma and weight loss. It sells Pharmacy (P) medicines. The pharmacy premises are closed to the public, so people access the pharmacy's services through its website, www.mypharmacy.co.uk or by telephone. It supplies some people with their medicines dispensed in multi-compartment compliance packs to help them take their medicines, and it delivers medicines to people.

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 appropriately identifies and manages most of the risks with its private online prescribing service. It maintains audits of prescribing to support the monitoring of the safety and quality of this service. The pharmacy has a process for team members to record and reflect on mistakes made during the dispensing process. It keeps records required by law and team members keep people's private information secure. And it has suitable processes in place to help team members safeguard vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). The SOPs were relevant to the services the pharmacy provided, which included both NHS and private services. They included processes involving controlled drugs (CDs), dispensing and other services including an SOP for the pharmacy's private online prescribing service and online sales of Pharmacy (P) medicines. The SOP for the online prescribing service was clearly written and described the checks the team was required to do when managing this service, for example, if an identity (ID) check was not successful. SOPs inspected were prepared in August 2021 and due to be reviewed in October 2023. The pharmacy had a training declaration sheet, where team members confirmed they had read and understood the SOP. All team members present during the inspection had signed the sheet.

The private prescribing service was only accessible via the pharmacy's website, www.mypharmacy.co.uk. The pharmacy provided risk assessments for the clinical conditions it provided prescribing services for. The prescribing policies were underpinned by The National Institute for Health and Care Excellence (NICE) and other evidence based clinical guidelines. These were read and signed by each remote based prescriber who provided the service. The risk assessments coupled with the pharmacy's own prescribing policies helped identify clinical risks for each condition. The pharmacy kept records of clinical decisions prescribers had made to supply medicines. However, prescribers didn't obtain independent verification of medical history for every diagnosed chronic condition. The pharmacy offered treatments for asthma. These included several types of inhalers. People were unable to successfully complete the online consultation questionnaire for asthma unless they provided evidence of documentation on their Summary Care Record (SCR) which demonstrated an asthma diagnosis, a recent asthma review and previous supply of the requested inhalers. A limit of three months treatment was in place for a repeat request of short-acting beta agonists such as salbutamol. The pharmacy adopted a similar policy for its online weight-loss service. People requesting treatment for weight-loss were required to allow the pharmacy access to their SCR. This was to enable the pharmacy's prescribers to exclude any mental health conditions, eating disorders, and to support them in verifying a person's weight and height. If a recent weight or height recording was not available on the SCR, the pharmacy requested for a video consultation between the prescriber and the person to be completed, or people could provide a photograph to verify the information provided. However, the pharmacy didn't have a method of confirming the photo provided was recent. The pharmacy's responsible pharmacist (RP) gave assurances that this risk would be mitigated by requiring people to provide a date-stamped photograph. The pharmacy required people to provide photographic evidence of their skin condition before being supplied any steroid creams. The pharmacy required consent from people for its prescribers to inform people's GPs of supply of medicines for asthma, weight loss and the supply of any antibiotics. If people did not consent, they were informed the pharmacy was not able to supply them

with medication. The pharmacy had policies and procedures in place which safeguarded against people potentially setting up duplicate accounts and submitting duplicate orders. It used a third-party service to complete necessary identity checks for all prescribing services and undertook its own identity checks if the initial check was deemed unsuccessful. These checks included requesting a copy of the person's driving licence or passport. These forms of ID were cross-referenced against details the person provided within the online order. The pharmacy's had no examples of where its own identity checks had failed.

The pharmacy had a process to record any mistakes made during the process of dispensing NHS prescriptions, which were identified before a medicine was supplied to a person. These mistakes were known as near misses. There was an electronic log for team members to use for recording near misses. Team members recorded details such as the name of the team member who made the near miss and the type of near miss. But some entries were vague and lacked specific details. For example, why a near miss might have happened. And so, team members may find it difficult to spot trends or patterns and make specific changes to the way they work to improve patient safety.

Team members were given roles and responsibilities. The accuracy checking dispenser was clear about which prescriptions they could check. These were either highlighted electronically on the IT system or for some prescriptions the RP initialled the printed prescription. Following the previous inspection, the pharmacy looked to strengthen the governance related to its prescribing service. It had done this by broadening the involvement and the responsibility of the RP. The RP completing clinical checks of prescriptions issued via the pharmacy's online prescribing service was now required to access the record of each completed consultation questionnaire to ensure the prescription was issued within the prescribing policy of the condition it related to. There was an intervention log which was used to document prescribing decisions that were challenged by the RP or where the RP made a request for further information from a person. Examples included interventions due to a person requesting medicines too frequently, and a person being refused treatment due to the prescription being issued outside of the pharmacy's clinical exclusion policy. The RP periodically completed an audit of each of the prescriber's prescribing activity between May and July 2023. The audit was designed to provide data across several conditions the pharmacy offered via its online prescribing service. It focused on identifying reasons why people using the service may have requested different medicines for the same condition or repeated requests for the same treatment. The RP was in the process of completing a new audit which looked at prescribing data between August and September 2023. The findings of both the intervention log and the prescribing audit were periodically shared with the RP and the prescribers. And they discussed the findings to review the pharmacy's processes. A recent discussion identified that two prescribers working at the pharmacy at the same time may not be able to identify multiple treatment requests from the same. The pharmacy implemented improvements to its system to inform all prescribers and the RP if multiple requests were being made at the same time.

A team member, who responded to email and telephone queries demonstrated how they dealt with concerns. And they confirmed concerns rarely needed to be escalated. Most concerns raised were about missing deliveries and refusal of sales of Pharmacy (P) medicines. And they were confident in resolving these situations, sometimes with the help of the accuracy checking dispenser. The pharmacy had received several online reviews and most reviews were positive. The pharmacy displayed some of the positive comments made by people on its website. The RP responded personally to any negative reviews with an apology and a brief explanation as to why the pharmacy may not have met the person's expectations.

The pharmacy had indemnity insurance which covered the online prescribing service. The policy included each of the pharmacy's prescribers and each of the prescribers had their own personal indemnity insurance. The pharmacy kept an up-to-date CD register which was completed according to

legal requirements. The physical stock matched the CD register balance for two medicines checked. The pharmacy recorded the destruction of CDs returned by people, and the record matched the returned CDs that were being stored in the CD cabinet. The pharmacy kept an electronic private prescription record for its private online prescribing service, and this also included private prescriptions it received from other private prescribers, such as veterinary prescriptions. The pharmacy kept an RP record, and a sample seen was complete. The pharmacy was displaying an RP notice, but not the one for the pharmacist who was working at the pharmacy on the day of the inspection. This was rectified when the inspector informed the RP of the issue.

The RP and each of the pharmacy's prescribers had completed level 2 safeguarding training via the Centre for Pharmacy Postgraduate Education (CPPE). Team members knew to refer concerns to the RP and to obtain details of local safeguarding contacts on the internet. The RP described how requests for emergency hormonal contraception (EHC) through the private online prescribing service by a male were highlighted and queried. This was to help the team identify and report any potential safeguarding concerns. People who may not receive their EHC medicines in time for them to be clinically suitable were contacted to upgrade to next day delivery. If they declined or this was not suitable, then the team referred them to their local pharmacy to obtain prompt treatment.

Principle 2 - Staffing ✓ Standards met

Summary findings

Team members working in the pharmacy have the appropriate skills to provide its services. And they have some opportunities for ongoing training to keep their knowledge up to date. They manage the workload well and support each other as they work. The pharmacy completes checks on the prescribers it uses for its private online prescribing service to ensure they have the appropriate competencies to prescribe medicines for the treatments it offers on its website.

Inspector's evidence

The RP was also the pharmacy's superintendent pharmacist (SI) and had overall responsibility for the pharmacy's governance. There were three other team members working in the pharmacy during the inspection. One was a full-time accuracy checking dispenser and one was a trainee pharmacy assistant who was enrolled onto an approved dispensing course. The third team member's role was limited to IT support, and they confirmed they didn't engage in any dispensing activity. The accuracy checking dispenser worked alongside the RP and managed the dispensing of NHS prescriptions. The trainee pharmacy assistant was mainly involved in managing online P medicine sales, organising refunds for cancelled orders, and packing medicines ready for delivery. The trainee worked closely with the RP and was required to discuss any queried orders with them. For example, any repeat requests for the same medicine. The RP then made the decision to approve or decline the request. The pharmacy also employed another qualified pharmacy assistant, another trainee pharmacy assistant, and a delivery driver. These team members were not present during the inspection. The delivery driver delivered NHS prescriptions to people living in the local area.

The pharmacy contracted two remote based pharmacist prescribers to assist with the online prescribing service. Team members based at the pharmacy premises had the contact details of each of the prescribers and reported they could contact them quickly to help resolve a query. There were two separate dispensing teams, one for the NHS services and one for the P medicine sales and online private prescribing service. And they worked in two separate areas of the pharmacy, with clearly defined workstations. Team members were seen working well together and managing the workload and the dispensers were able to work across the different areas to cover absences.

The RP kept his knowledge and skills up to date as part of his continuing professional development (CPD) for professional revalidation. This included checking prescribing guidelines issued by NICE for medicines supplied by the pharmacy. The RP was able to show evidence that the prescribers had undertaken training and courses that were relevant for the prescribing services the pharmacy was offering. This covered initial training and subsequent CPD for the relevant clinical areas. The prescribers had experience working in primary care settings and the one of the prescribers also worked part of their week regularly as an advanced practitioner pharmacist based in general practice.

Other team members didn't have formal ongoing training plans to keep their knowledge up to date. But they described how the RP trained them on any new systems that were introduced and any changes in the law or service provision. They regularly spoke together as a team, including about the ways services were provided and a team member described how they felt comfortable sharing ideas or raising concerns with the RP. Team members had received an appraisal in the last year, and in the meeting had discussed their performance, planned how to improve and what support was needed. The RP had

previously arranged ad-hoc telephone calls with the prescribers to discuss company related news and matters related to the pharmacy's prescribing guidance. The RP explained they had decided to incorporate, monthly remote meetings with the prescribers to help support them to continue complying with the guidance and inform them of any changes. The pharmacy didn't set any targets for services and prescribers were not financially incentivised to prescribe any medicines.

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 is professional and easy for people to use.

Inspector's evidence

The pharmacy was closed to public access and the entrance was secured against unauthorised admission. The pharmacy was in an adequate state of repair. On the ground-floor there was a large dispensary with a good amount of bench space and medicines storage for the workload. Medicines were stored in a tidy way, with space between different medicines and strengths. There were many rooms that were unused, and these were accessible through one door that kept the area separate from the area the pharmacy team used for services.

There were staff facilities with hot and cold running water and hand washing facilities. The dispensing area had a separate sink and hot and cold running water. The main pharmacy area was at a suitable temperature. There was sufficient lighting.

People accessed services through the pharmacy's website. The pharmacy's website displayed the voluntary GPhC logo. The name and physical address of the pharmacy was displayed on the website, and it was designed so the registration status of the pharmacy could be found by following the link from the GPhC logo. The website displayed the details of the pharmacy team, and the name and photograph of the RP was clearly displayed on the 'about' page. The registration status of the RP and the other prescribers could be found by clicking on their names. People accessed the consultation questionnaire from a page listing the conditions the pharmacy treated. People were asked to answer a series of questions to help prescribers determine their suitability for treatment. The consultation questionnaires were suitable for the treatments prescribed.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has sufficient safeguards in place to ensure it manages its private online prescribing service safely and effectively. But the pharmacy doesn't always ensure it receives evidence of a person having been diagnosed with an existing condition. The pharmacy manages its other services appropriately. It obtains its medicines from appropriate sources. And team members carry out regular checks on medicines to make sure they are fit for purpose.

Inspector's evidence

People accessed services through the pharmacy's website and by contacting the pharmacy by telephone and email. The pharmacy's website detailed how to access both NHS and private services. This included explaining how to access the private online prescribing service and for the sale of medicines. The pharmacy had an NHS distance selling contract.

Prescribers worked remotely and had access to people's responses to the online consultation questionnaires and their SCR to support them in verifying people's medical history and subsequent suitability of treatment. For example, when considering treatment for weight loss or asthma. However, the pharmacy didn't have systems in place to complete this process routinely for other long-term conditions which required an existing diagnosis or evidence of previous supply of the requested medication via their GP. For example, when considering treatment for migraines. There was therefore a risk that prescribers were not provided with the full information about a person's medical history which may have influenced their prescribing decision. Following the inspection, the RP gave assurances that consideration would be given to expanding the scope of treatments that would require prescribers to access information to verify an existing diagnosis or previous supply. For example, photos of skin conditions such as eczema. The pharmacy had required people to provide mandatory consent for their GP to be notified of any authorised treatment by the pharmacy for weight-loss, asthma and any services that resulted in the person being prescribed an antibiotic. But consent to notify people's GPs following treatment for other conditions was not made mandatory. For example, erectile dysfunction or eczema. Notifications to GPs were in the form of a letter which outlined the details of the medication supplied but didn't include any reasons of why the treatment was authorised. The pharmacy retained records of interventions and refusals for people who had requested treatment repeatedly, had ordered medication well in advance of any previous supply finishing, had declared symptoms that would exclude them from treatment or had a medical condition indicated on their SCR that would make them unsuitable for treatment. The pharmacy kept records of each consultation with people and each intervention, on its computer system. It maintained records of when people's SCRs were accessed and if a video consultation had taken place between a prescriber and a person. The pharmacy kept records of emails sent to people who had requested treatment via the prescribing service, as well as any responses people had made. There were records kept of when prescribers had refused treatment.

Following the previous inspection, the pharmacy had taken steps to improve its online questionnaire. People were required to complete an online questionnaire to assess their suitability for treatment. Once suitability had been confirmed, people were then able to select a medicine for treatment. Previously, people were able to resubmit their answers to the questions within the questionnaire if they were initially deemed unsuitable for treatment. People were able to attempt questionnaires up to three times within a 24-hour period. Prescribers were now provided with the number of attempts a person

had made, and so could use this information to help them exercise their own professional judgement in making a prescribing decision. The RP demonstrated examples of where treatment had been refused, or further information had been requested, after a person had made two attempts. People were 'locked out' and unable to make any more attempts if they had changed their answers on three occasions.

Once a prescription had been authorised by a prescriber, it was sent electronically to the pharmacy for dispensing. The RP completed both an accuracy and clinical check of the prescriptions. Checks were made on the person's previous supplies and the consultation questionnaires responses. The RP was therefore able to ensure supplies were appropriate and in line with the pharmacy's medication guidelines document. For example, there were checks on body mass index (BMI) changes.

Dispensing for the pharmacy's private online prescribing service and P medicines sales were managed in a separate room from dispensing NHS prescriptions, to ensure the services were kept separate. The pharmacy used baskets for dispensing all prescriptions and processing P medicine sales. This was to avoid different people's medicines from being mixed up. It had separate workstations for team members, in both areas and there was a clear workflow to reduce risk of error. Team members demonstrated their individual logins that allowed access to the electronic PMR system. This created an audit trail of tasks completed in case of queries or for learning following errors. The workflow of all dispensing and checking was clearly visible in the workflow plan in the dispensing system. The RP had good visibility of the workload and the tasks being completed by each of the team members. Team members had knowledge of the risks associated with dispensing valproate for people who may become pregnant. They described how they took this into consideration when completing the clinical check on prescriptions before they were released for dispensing. The pharmacy had limits on the number of several higher-risk packs of P medicines people could order at any one time. For example, people were only permitted to order a single pack of Piriton 4mg x 100 tablets. All medicines containing codeine or pseudoephedrine were limited to a single pack per person per month. Any orders made for more than one pack were automatically refused.

The PMR system used barcode technology throughout the dispensing process, so barcodes were printed on the dispensing labels and name and address bag labels. This tracked people's medicines through the dispensing and delivery process. For example, for NHS services, the team knew which medicines had been delivered to and been received by the care homes. Team members scanned the manufacturer's barcode as part of the labelling process, to help identify any selection errors before the final check. The accredited accuracy checkers completed the final accuracy check, using the barcode technology. They checked medicines dispensed in split packs, fridge lines and other medicines such as valproate, as authorised through the clinical check. They were not authorised to check CDs. The RP completed the final accuracy check on medicines that the accuracy checkers had dispensed, including for multi-compartment compliance packs. There was a manual process of inputting the invoice number on the prescription to print the postal label, as there was no barcode associated with this system. The team members packing and labelling the prescriptions for delivery by post and courier, made a series of checks as they worked to reduce errors.

The pharmacy dispensed medicines in multi-compartment compliance packs for people living in the community. They used the PMR system to record when the prescriptions were ordered and then used these details to check the accuracy of the prescriptions they received back from the surgery. This was completed in advance of the packs being needed, so they had time to query any missing items with prescribers. The pharmacy printed backing sheets with details of the name of the medicine, the time of administration and with visual descriptions of the medicines. The dispenser scanned the manufacturer's barcode prior to assembly to help ensure they had selected the correct medicines. The pharmacy supplied medicines for people living in care homes in the original manufacturer's packs and supplied

these with medication administration records (MARs).

An employed delivery driver delivered to people who lived locally. This was mainly for NHS prescriptions and included delivering to people living in care homes. The pharmacy used the postal service and a recognised courier for delivery of medicines for its private services and medicine sales. People had the option of 48-hour delivery or the use of a courier for more urgent deliveries within 24 hours. Team members processed prescriptions requiring different delivery methods separately. The pharmacy had the ability to track prescriptions delivered by post and couriers, and by their delivery driver. The pharmacy used an electronic delivery solution for prescriptions delivered by the employed delivery driver. There were records which indicated which prescriptions were being delivered that day and the system held records of completed and failed deliveries. The driver took photographs of signatures and packages on the doorstep as evidence of a successful delivery.

The pharmacy obtained medicines from recognised wholesalers. It had medicinal waste bins for pharmaceutical waste, stored appropriately. It had an up-to-date rota for checking expiry dates of medicines, and the team regularly used red stickers to highlight short-dated stock. No out-of-date medicines were found on the shelves following a check of approximately 20 medicines. The pharmacy had a large medical-grade fridge, which was operating within the required temperature range during the inspection. The team recorded the fridge temperature daily as seen by the records. The fridge was kept tidy, using baskets to keep medicines separated. The pharmacy received drug alerts via email. The RP actioned each alert as soon as possible and kept a record of the action taken to maintain a robust audit trail.

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 reference resources and use of the internet to obtain up-to-date information. It had a clean glass CE marked measuring cylinder for liquids, but also had two plastic non-CE marked measures. These were highlighted to the team at the previous inspection but had not been replaced. The pharmacy had password-protected computers and members of the team used their own NHS smart cards.

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.