General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rightangled Pharmacy, 32 Galena Road, Hammersmith, London, W6 0LT

Pharmacy reference: 9011933

Type of pharmacy: Internet / distance selling

Date of inspection: 03/04/2023

Pharmacy context

This is a distance-selling pharmacy (https://rightangled.com/) with an online prescribing service. The pharmacy dispenses private prescriptions generated by a team of pharmacist and nurse independent prescribers and sells over-the-counter medicines. The types of medicines mainly dispensed include treatments for weight management and hair loss. The pharmacy is closed to the public and medicines are delivered to people via courier.

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. It has not fully considered and addressed the risks of prescribing medicines largely by relying solely on an online questionnaire without getting further information from people. And its prescribers do not follow some of the safeguards it has to reduce the risks of supplying medicines to people which may not be clinically appropriate.
		1.2	Standard not met	The pharmacy does not check that its services are being provided safely. For example, the pharmacy does not review how medicines are prescribed. Or that system-led checks or refusal mechanisms are working in practice.
		1.5	Standard not met	The pharmacy is not able to demonstrate that it has adequate indemnity insurance to protect people using its services.
2. Staff	Standards not all met	2.2	Standard not met	Pharmacy staff are not always suitably trained or doing the right accredited training for the activities they undertake.
		2.3	Standard not met	The pharmacy does not have adequate professional oversight to make sure medicines are only supplied to people when safe and clinically appropriate.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website allows people to start a consultation from the page of an individual prescription-only medicine. This does not meet GPhC requirements.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy cannot demonstrate that it gets enough reliable information about people to make sure the medicines it supplies, including for weight loss, are clinically appropriate for them. And it cannot show that it has appropriate monitoring in place when supplying prescription medicines such as weight-loss treatments.
5. Equipment	Standards	N/A	N/A	N/A

Principle	Principle finding	Exception standard reference	Notable practice	Why
and facilities	met			

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

Summary findings

The pharmacy does not manage and identify all the risks associated with the services it provides. It has carried out some risk assessments and audits but does not properly review all its services to make sure that they are safe for people to use. For example, the pharmacy does not carry out reviews to check that medicines are prescribed appropriately, and system-led checks or refusal mechanisms are working in practice. And it doesn't make checks about how the prescribing service shares and receives information from people's own GPs to make sure this information is used effectively to protect people's health and wellbeing. It does not monitor if people change their responses during consultations to get supplies that may not be appropriate. And it does not always follow its own procedures to manage the risks it has identified. The pharmacy does not have appropriate indemnity insurance for all its services. For example, supplying medicines to the United States and Australia.

Inspector's evidence

The pharmacy's business involved the supply of prescription-only medicines (POMs) and over-the-counter medicines (both pharmacy medicines (P) and General Sales List (GSL) medicines) through its website to people mainly based in the UK but there were also some supplies made to other countries such as Australia, Japan and the United States of America. The pharmacy had current indemnity insurance for the prescribing service and the other pharmacy services. But the pharmacy couldn't demonstrate that this insurance covered supplies of medicines made to all people based abroad. Each of the prescribers had their own independent insurance cover.

POMs were supplied against private prescriptions issued by one of the pharmacist independent prescribers (PIPs) or nurse prescriber. The pharmacy's website had treatments available for a wide range of conditions such as erectile dysfunction, hair loss and weight loss. People were required to complete a questionnaire to purchase over-the-counter medicines or be prescribed POMs. The pharmacy's prescribers relied on the answers provided by people on the questionnaire to make a prescribing decision. They did not independently verify a person's medical history or weight using any other means. This meant there was a risk that these medicines were prescribed for people for whom they were not safe or appropriate. This was despite the risk assessment for weight loss stating it was mandatory for photo evidence. Following the inspection, the prescribers informed that some changes had been made and it was mandatory to obtain photographic evidence of the weight before issuing any prescriptions.

Standard operating procedures (SOPs) were available and in date. SOPs had been read and signed by the superintendent pharmacist (SI) who was also the regular responsible pharmacist (RP).

Risk assessments for the service had been completed and covered a range of medical conditions. These included treatments for weight loss, erectile dysfunction, combined oral contraception, allergic rhinitis, emergency hormonal contraception (EHC), chlamydia and the over-the-counter products such as pain relief medicines. There were two risk assessments for weight loss, one was for orlistat and the other was a general one. The general one did not reference the actual products prescribed and supplied. There was no specific guidance to cover prescribing of Saxenda or off-label prescribing of Ozempic and Rybelsus. The prescribers explained they referred to the product characteristics for Saxenda and used

their own clinical judgement for Ozempic. The prescribing guidelines that were within the risk assessments were in line with national guidance. These had been written by one of the previous SI's who no longer worked at the pharmacy. Risk assessments and SOPs had not been reviewed by the new SI. Each risk assessment had the name of the previous SI and the final sign off with a date of when it was due for the next review.

Risk assessments for each condition took into account the description of activity, identified hazards and had controls and safeguards recorded to mitigate these risks. There were inclusion and exclusion criteria and a risk assessment summary. As an additional safeguard, the risk assessments also had 'stop gaps'. These were to ensure that people were not over-ordering and were reducing the amount of supplies they are given over a defined period. However, these safeguards were not always being followed. There was evidence that people were managing to obtain multiple packs of Nurofen plus or Syndol at a time and, on some occasions, a combination of both. Following the inspection, the owner confirmed they had implemented a supply limit on quantities and people could only order one pack at a time for either of those products. He also confirmed and provided evidence that the pharmacy had implemented a mandatory checking step to review the date of the last order placed by someone and, in the case of repeat orders, the pharmacy would not supply a pack within 56 days of the patient's last order.

The director stated that if a person provided consent, the pharmacy would send information to the GP about the medicines it had supplied and there was some evidence this was being done. But the pharmacy was more often making supplies of POMs to people without sharing information with the person's own GP, even where consent to do so was a requirement of providing the service and set out in the pharmacy's risk assessment. For example, for the weight loss medicines, the pharmacy's risk assessments insisted that people consent to allow the pharmacy to share information with their regular GP before a supply was made. But there was evidence that people were supplied these medicines without providing consent to share information with their GP.

The pharmacy had not completed any clinical audits, prescribing reviews or appraisals of the prescribers. The owner said he planned to complete a prescribing audit after three months of the service being provided. An audit had been completed on the number people who had consented to share information with their GP. The findings were that it was only 34% but no learning or actions were taken from this information despite it stating in the weight loss risk assessment that sharing information was mandated.

In most cases, people were provided with an information leaflet about how to take the medicines they were prescribed. But it was unclear if people were informed and understood that certain medicines were being prescribed outside the licensed uses of the medicine. And there was no counselling provided for medicines such as Rybelsus which had to be taken on an empty stomach with water, 30 minutes before eating , drinking, or having any other medicines.

The director said there had been no dispensing mistakes since the pharmacy opened. There was no evidence of reporting or learning from prescribing errors or reviews.

The pharmacy's system maintained an audit trail and the record showed which prescriber had issued each prescription. However, prescriptions did not have an electronic signature and only had the initials of the prescriber. This meant there was a risk that the private prescription could be edited. In addition, three supplies of Ozempic could not be matched to prescription forms during the inspection and the owner could not locate prescriptions for these supplies. Following the inspection, the prescribers confirmed that electronic signatures had been introduced which were solely under the control of the individual prescriber.

The correct RP notice was displayed. RP records were generally well maintained. Private prescription records were made on the system. The director usually started work before the SI started and had signed in. In this time, he printed labels and dealt with queries. The director had not completed and was not enrolled on any accredited dispenser training course. A number of consultation records were viewed and most of the necessary information from the questionnaire was kept along with information of the treatment plan. The pharmacy team and prescribers had access to any communication made between the person and the pharmacy team and prescribers. Prescribers had completed safeguarding training as part of their training at other workplaces.

Information about raising complaints was available on the pharmacy's website. People could contact the pharmacy via email to feedback and concerns. The owner was looking into having customer satisfaction feedback surveys.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough team members to assemble and prepare prescriptions. But not all people working in the pharmacy have completed or are undertaking the appropriate training for their role. Team members including prescribers can communicate and share information with each other. But the pharmacy cannot demonstrate it has adequate professional oversight to ensure medicines are supplied safely by the pharmacy.

Inspector's evidence

The pharmacy team comprised of the director and the RP, who was also the SI. The director had not completed any accredited dispenser training courses but was involved in creating dispensing labels. Two pharmacist independent prescribers and a nurse prescriber worked for the company and issued prescriptions. The prescribers worked remotely, and the RP clinically checked the prescriptions. Prescribers were available during the working day and in the event of absences another prescriber would step in. The pharmacy had planned to recruit more prescribers. Since the inspection the pharmacy had employed a doctor to be the clinical lead.

There was evidence for two of the prescribers about weight management courses they had completed. However, there was no similar information provided for the other prescribers. The director said all prescribers had access to all the risk assessments and were asked to declare that they had read and understood them, but the evidence for this was not seen. However, there were no risk assessments for Saxenda, Ozempic and Rybelsus. The prescribers explained that they referred to the product characteristics for Saxenda and used their own clinical judgement for Ozempic when prescribing either of these medicines. It was unclear how experienced they were in this.

There was no evidence of peer reviews or appraisals undertaken. At the time of the inspection, the prescribers were not supervised in any way. However, following the inspection, the director and prescribers said that the pharmacy had appointed a clinical director who oversaw and provided feedback to the prescribers for the consultation they had undertaken. Details of the clinical director were also seen to have been added to the pharmacy's website. Furthermore, the prescribers were being enrolled onto a specialist weight management programme to enhance their skills and knowledge.

The SI was unable to answer a number of questions in relation to the over-the-counter sales of medicines during the course of the inspection. This included the maximum quantities of some medicines that could be sold over the counter .

The team used an online messaging application to communicate; this was also the platform used by the prescribers to communicate with each other. Prescribers gave verbal feedback to the director regarding ways to improve the service. Prescribers were encouraged to use their own professional judgement when prescribing. Examples were seen where orders had been rejected due to incorrect weight being submitted.

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

Summary findings

The pharmacy's website allows people to select a prescription-only medicine prior to having a consultation. And this is contrary to the GPhC Guidance for registered pharmacies providing pharmacy services at a distance, including the internet. However, the website now gives people information about the prescribers the pharmacy uses. So that people can check who prescribes their medicines. The premises are clean, and they are secured from unauthorised access.

Inspector's evidence

The pharmacy's services were accessed via the Rightangled website. The website gave the address of where medicines were supplied from. But it did not display names of the prescribers, where they were based or show who the RP and SI were. After the inspection, details of the prescribers had been added to the website along with their registration numbers.

The pharmacy's website allowed people to select a POM prior to receiving a consultation. A 'start your online consultation to order' button was found on pages for POMs. People were also able to use the search function to find medicines by name. And so, people could select a POM prior to receiving a consultation. Following the inspection, the 'start your online consultation to order' was changed to 'back to start consultation.' However, this still launched into the consultation from the page which was contrary to the GPhC guidance.

The pharmacy premises were clean. Medicines were stored on the shelves in a tidy and organised manner. Workbench space was tidy and organised. There were adequate hygiene and handwashing facilities for staff. The pharmacy was closed and could not be accessed by the public, and contact was via telephone or email. The pharmacy was secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services at the time of the inspection.

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

Summary findings

The pharmacy's services are not always managed effectively, to protect people's health and wellbeing. The pharmacy does not make sure there is adequate professional oversight of all medicines it supplies. And it does not make sufficient checks or follow its own processes to ensure that all the over-the-counter medicines it supplies are appropriate for people. Prescriptions are issued to people without adequate checks to verify information supplied by people. And its prescribers don't make a clear record at the time explaining their justification for prescribing when there is no consent to share information with a person's own GP. This increases the risk that the pharmacy supplies prescription medicines to people which are not clinically appropriate, and people's conditions might not be properly monitored. However, the pharmacy obtains its medicines from reputable sources, and it stores them properly. And it gives people additional advice about obtaining emergency contraception when it can't supply this treatment in a timely way.

Inspector's evidence

People using the pharmacy's services were required to create an account after completing the online consultation questionnaire to checkout their basket. Identification (ID) checks were carried out by a third-party organisation. The director said prescriptions were not processed if the ID check was not completed. Once the order was processed, people needed to submit a photo ID such as a copy of their driving licence or passport. The name on the account needed to match the name on the ID submitted and packages were only shipped to the name on the account.

Medicines were supplied against information provided on questionnaires. There were a series of questions and free text boxes where people could submit their answers. Although the questionnaires asked about medical and drug history, there was limited evidence of extra safeguards being in place to mitigate the risks of prescribing weight loss products, especially those that were being used off-licence. There was no evidence of the pharmacy referring to people's Summary Care Records or obtaining a confirmed clinical summary or medical history from the GP surgery or any evidence of looking at a confirmed list of repeat medication the person may be taking. For weight-loss medicines, the prescriber reviewed the answers submitted via the questionnaires and checked that the BMI was in line with the guidance and then made a decision to supply. The prescribers did not independently verify the person's medical history or what medication they were taking. Orders from people with a low BMI were said to be automatically rejected, but there was some evidence of supplies being made when the person had a low BMI. Repeat orders for weight loss medicines required the prescriber to confirm the person had lost weight by using the medicine. The decision on whether to independently verify information provided by people using the online questionnaire or via a conversation with the person was at the prescriber's discretion and professional judgment. Following the inspection, the pharmacy had introduced a mandatory verification of the weight with people needing to send in a photograph.

There was an antibiotic prescribing policy to remind prescribers to follow the stop-gap policy to avoid unnecessary over prescribing of antibiotics. It was seen that the risk assessment stop-gap limit for azithromycin for the treatment of chlamydia was 14 tablets over 60 days. This meant that a person could potentially receive treatment antibiotics several times over a 60-day period. However, there was no evidence this had happened. The pharmacy had stop-gaps in place for products such as Nurofen Plus and Syndol, but these were not always being followed. However, since the inspection, the pharmacy

had implemented changes as described in Principle 1 to reduce the chances of supplying too many or too frequently.

The pharmacy posted out medicines to Japan, Australia, the United States of America and within the UK. The director said he had checked if the medicines could be sent to the relevant countries. However, it was unclear if these supplies were covered by the pharmacy's indemnity insurance cover as described in Principle 1.

The prescriber contacted people via the online communication platform or telephone. A patient information leaflet was given, and people were also advised what the dose was and how to take the medicine. The prescribers also advised that they would try and give counselling advice and lifestyle advice. However, it was unclear whether the prescribers confirmed that people understood they were receiving off-label treatment such as Ozempic for weight loss. Once the person had agreed to the treatment, a private prescription was generated. This was then sent to the pharmacy to clinically check where it was reviewed by the RP. Once checked, medicines were then assembled ready to be dispatched. Labels were printed by the director. He said other than printing the labels he was not involved with the dispensing. There was no evidence to show the RP had intervened when a person was prescribed a medicine in circumstances that the risk assessment would have ruled ineligible. And multiple orders for Nurofen plus had been supplied to people also without apparent intervention by the RP.

People were able to contact the pharmacy if they needed to. Their query would be passed on to the appropriate team member or prescriber. People were also able to seek advice from the prescribers at any time. For repeat supplies of weight-loss medicines, the person had to fill out the questionnaire for each supply and would be reviewed every three months by the prescriber to assess weight loss and whether it was safe to continue treatment. The weight loss progress was checked via an online questionnaire without any independent verification of weight loss made over the three-month period.

Emergency contraception was available to purchase via the website. This was available for next day delivery. This was made unavailable over weekends and bank holiday weekends with people signposted to visit their local pharmacy as deliveries would not have been received within the required time for taking the medication.

Medicines were packed in padded envelopes or boxes depending on what was contained in the order. Medicines which were temperature sensitive were packed in insulated fridge pouches with two cooling bags and were sent using the fastest delivery method. Delivery of medicines was via Royal Mail and were tracked and had to be signed for. International deliveries were carried out by DHL. The owner described how the company who supplied the temperature sensitive packaging had verified that the temperature was maintained. The pharmacy had not completed any independent checks to verify or test this. Uncollected packages were returned to the pharmacy. The owner confirmed that any medicines that came back this way would be destroyed.

Medicines were obtained from licensed wholesalers. The pharmacy held very little stock and expiry dates were clearly recorded. The pharmacy had a waste bin to separate returned and expired medicines. This was collected by a third-party company. Fridge temperatures were monitored and recorded and were seen to be within the required range for the storage of medicines. The pharmacy did not supply any controlled drugs which were not available as over-the-counter medicines. The RP checked drug recalls online.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. It uses its equipment to help protect people's personal information.

Inspector's evidence

Reference sources were available including access to the internet. The electronic patient medication record system was password protected. Confidential waste was shredded. As the pharmacy was closed to the public this helped to 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.