General Pharmaceutical Council

Registered pharmacy inspection report

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

Pharmacy reference: 9011933

Type of pharmacy: Internet / distance selling

Date of inspection: 15/01/2024

Pharmacy context

This is a distance-selling pharmacy which provides its services via its website (https://rightangled.com/) and has an online prescribing service. The pharmacy does not provide NHS services. It dispenses private prescriptions generated by a team of pharmacist 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 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 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 adequately manages the risks associated with selling medications online. It largely keeps the records it needs to by law and has procedures in place to learn from mistakes. It holds regular meetings and reviews to see how team members can learn from mistakes. It also completes risk assessments and audits to help ensure that its services are provided safely. It makes action plans to identify improvements that should be made to its services. But it does not always implement these actions in a timely way.

Inspector's evidence

The pharmacy supplied prescription-only medicines (POMs) and over-the-counter medicines (mostly pharmacy medicines (P) medicines) through its website to people mainly based in the UK. The pharmacy made some supplies to other countries such as Australia and Japan, however, since the last inspection, it had stopped making supplies to residents of some countries, namely the United States of America, Spain and Italy. The pharmacy had current indemnity insurance for the prescribing service and the other pharmacy services, and these covered supplies of medicines made to people based abroad (with exception of the United States of America).

POMs were supplied against private prescriptions issued by one of the pharmacist independent prescribers (PIPs) who worked remotely. 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. Since the last inspection, the pharmacy had introduced mandatory consent to share details with the person’s general practitioner (GP) when requesting certain POMS such as those for weight loss. There was evidence seen of the pharmacy sharing information with the person's own GP.

Standard operating procedures (SOPs) were held electronically and were in date. SOPs had been read and signed by current team members.

Since the last inspection, the pharmacy had employed a clinical lead who was a GMC-registered doctor. The clinical lead was responsible for completing monthly clinical audits, prescribing reviews and appraisals of the prescribers. The pharmacy provided risk assessments for the clinical conditions it provided prescribing services for. The prescribing policies were underpinned by NICE and other evidence-based clinical guidelines. The risk assessments did not identify operational risks associated with using a questionnaire-based consultation method such as people potentially setting up duplicate accounts and or submitting duplicate orders. The pharmacy did however have processes in place to mitigate these risks by using a third-party ID checking company and had a system that flagged any potential duplicate accounts. The pharmacy also manually checked people's accounts for previous orders to ensure that requests were not made too early. The pharmacy allowed for a different delivery address to a person’s billing address when requested but ensured that the named person remained the same. The risk assessments combined with the pharmacy’s prescribing policies reflected clinical risks for each condition. For example, there were clinical justifications for the request of medicines for the conditions based on the history of the presentation and relevant exclusion criteria based on

precautions or 'red flag' symptoms. However, the pharmacy had no way of verifying this information independently. For example, it asked people if they had a positive diagnosis of herpes by their GP or genitourinary medicine clinic as a criteria for commencing treatment but did not request any evidence for this. It was left to the PIP's professional judgment to call a person's GP if they felt additional information was required or if information needed to be confirmed for any of the conditions the pharmacy supplied a prescribing service for, but this was not done for every person. This meant that a person who may have a medical condition that would exempt them from being suitable to have a particular medication could potentially receive a supply of medication. Furthermore, the specifics of what was discussed or verified when a person's GP surgery was contacted was not always documented by the prescribers. Following the previous inspection, the pharmacy had updated its policy for weight-loss medication and now requested that each person submit a photo of their body shape alongside their body mass index. This was introduced to safeguard supplies to vulnerable people and to ensure that the medication was only being issued to people who fulfil the clinically obese criteria. But it did not request a date stamp of these photos so there was no way of verifying if it was a recent photo. People were required to give mandatory consent to notify their GP about any weight-loss medicines prescribed. The pharmacy's prescribing was undertaken by prescribers working remotely. This meant that a different pharmacist was involved for clinical and final accuracy checks.

The pharmacy employed a clinical lead medical doctor who regularly audited the pharmacists' prescribing and provided regular feedback in writing to them and to the superintendent pharmacist (SI). It had been highlighted in several audits the need to place greater emphasis on clinical reasoning when prescribing medications, the need for consistent and comprehensive documentation and to implement additional checks to further enhance patient safety. Subsequent actions plans had been put in place to improve practice but the results of these actions were yet to be implemented, for example, the prescribers were yet to be enrolled onto a training course which focused on weight loss medication.

The pharmacy separated the functions of the prescriber pharmacist from the functions of the Responsible Pharmacist (RP). This ensured that the prescriber pharmacist was not the pharmacist undertaking the final clinical and accuracy checks.

Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were documented electronically, reviewed monthly and discussed with the wider team. Team members described making some changes following near misses, for example, separating certain medicines and creating separate storage areas for parcels to be dispatched. A procedure was in place for dealing with dispensing mistakes which had reached a person (dispensing errors), which included documenting the mistake.

The pharmacy's system maintained an audit trail and the record showed which prescriber had issued each prescription. Following the last inspection, the pharmacy had introduced electronic signatures which were solely under the control of the individual prescriber, rather than using the initials of the prescriber as had previously been done. This helped reduce the risk that the private prescription could be edited. Prescriptions were also attached to all orders so that they could be referred to if needed.

The pharmacy had an onboarding process for each one of their prescribers which included ensuring that appropriate indemnity arrangements were in place. The correct RP notice was displayed. RP records were generally well maintained. Private prescription records were made on the computer system. A number of consultation records were viewed, and most had the necessary information, however, some records did not have robust reasons for supply and simply stated 'suitable to prescribe.' The pharmacy did not always document if it had contacted the person's GP for additional information. It kept records for the refusal of medication requests and onward GP notification. It kept

records for the refusal of medication requests and onward GP notification.

Team members had completed the relevant safeguarding training for their role. Information about raising complaints was available on the pharmacy's website. People could contact the pharmacy via email to feedback and concerns. The pharmacy also conducted feedback surveys using third party providers and showed examples of positive feedback that it had recently received.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified for their roles and the services they provide. They can communicate and share information with each other, and they are provided with the opportunity to provide regular feedback.

Inspector's evidence

The pharmacy team comprised of the director, the RP (who was also the SI), a qualified dispenser, and a customer service agent. Three pharmacist independent prescribers issued prescriptions remotely. The clinical lead also worked remotely, oversaw the PIPs and was involved in providing training, conducting audits and carrying out risk assessments. Prescribers were available during the working day and in the event of absences another prescriber would step in. The SI started her shift later than other team members on site. Team members said that only administrative tasks were completed in the RPs absence.

The SI said that her responsibilities included clinically checking the prescriptions that had been generated by the PIPs, ensuring the pharmacy was running safely, and updating the PIPs of any changes or recommendations. For example, she was in the process of sending information about a new weight loss medicine to the PIPs. She was also involved in carrying out the clinical audits and risk assessments. She said that she could openly raise concerns to the director and clinical lead, and had shared some of her recommendations, for example, the course duration for treating bacterial infections. The SI kept her skills and knowledge up to date by reading pharmacy articles and researching treatments, including treatments that were not provided at the pharmacy, such as the new Pharmacy First service. She felt that having a wider knowledge enabled the team to signpost people to the most relevant services.

The dispenser had recently started working at the pharmacy and said she had read the pharmacy's SOPs and had been provided with additional in-house training on the systems and processes. The customer service agent had a good understanding of the pharmacy's services and was able to locate several documents such as the SOPs, audits and risk assessments. She had been provided with training by the director but also had experience in customer service at a previous role.

The clinical lead oversaw and provided feedback to the prescribers for the consultations they had undertaken. He was also responsible for conducting regular appraisals with the prescribers. Details of the clinical director were also seen to have been added to the pharmacy's website. Following the previous inspection, the pharmacy proposed and agreed to their prescribers enrolling on a nationally recognised course for weight loss, but this had not been actioned. Instead, the clinical lead had developed in-house training for their pharmacist prescribers, but the pharmacy did not provide evidence of its content. The pharmacy showed evidence of other ongoing training, such as case study discussions which were held during the team's monthly meetings. Following the inspection, the director sent copies of training certificates to confirm that the PIPs had completed external training on weight loss medication.

The prescriber pharmacists were able to demonstrate refusals on requests for medication where the patient's request did not comply with the pharmacy's own risk assessments and prescribing policies. Letters to notify a person's GP were mandatory for certain conditions, for example weight loss

medication, and were seen on inspection.

Team members were able 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 and the processes in place to minimise inappropriate supplies of medicines that could be abused.

Monthly meetings were held to discuss any issues, feedback, or areas for improvement. The team also used an online messaging application to communicate. Prescribers gave verbal feedback to the director or clinical lead about 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 incomplete or incorrect information being provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's website gives people information about the pharmacy. And it gives details about the prescribers it uses so that people can check who prescribes their medicines. The premises are clean and they are secured from unauthorised access. The pharmacy's website highlights to people if any answers on the questionnaire would result in a supply not being made and allows people to potentially change their answers before submitting it. And this could mean that people potentially give incorrect information to try and obtain a supply of a medicine.

Inspector's evidence

Following the previous inspection, the pharmacy changed the layout of the website. The consultation flow had been updated where users had to first complete the consultation forms before they were able to select a medicine. People could no longer select their preferred medication before completing the questionnaires for the medical condition.

The pharmacy's address was displayed on the website to show people where their medicines were being supplied from. The website displayed the names of the clinical lead and the PIPs, their registration numbers and their role.

If a person answered the questionnaire on the website for weight loss, the website allowed the person to go back and change their answers if they did not meet the criteria for having the medicine prescribed. The website allowed a person to have unlimited attempts and did not notify the prescriber how many attempts the person had at providing responses to the questionnaire. This could allow people to potentially circumvent the system and change their responses to their questions to try and obtain a supply. The director said that he would be reviewing this and implementing some changes to prevent this from happening in the future.

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 met

Summary findings

On the whole, the pharmacy generally provides its services safely and effectively. It obtains its medicines from reputable sources, and it stores them properly. And it signposts people to other service providers when necessary. The pharmacy takes some steps to ensure that it reviews people's treatment for certain medical conditions. But it does not keep the information from the reviews about people's weight loss treatment on the individual person's record. And this may make it harder for the prescribers to easily access this information in order to help assess the suitability of the treatment.

Inspector's evidence

People could access the pharmacy's services via its website. 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 conducted by a third-party organisation. Once the order was processed, people needed to submit a photo ID such as a copy of their driving license or passport, as well as a photograph if they were requesting weight loss medicine. 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. People requesting weight loss medicines were asked for their height and weight and they were not prompted if their answers did not meet the threshold. The pharmacy did not have access to people's Summary Care Records. For weight-loss medicines, the prescribers reviewed the answers submitted via the questionnaires and checked that the BMI was in line with the guidance and then made a decision whether to supply. Repeat orders for weight loss medicines required the prescriber to confirm the person had lost weight by using the medicine. Orders for those who did not lose at least 5% of their body weight within six months were rejected. But they were signposted to other service providers such as their GP or NHS website, to ensure continuity of care. GP notification was mandatory for the supply of weight loss medication.

The pharmacy had governance procedures in place such as risk assessments and prescribing policies. But there was currently no process of oversight to inform the prescriber about how many attempts a person had on the questionnaire-based consultation. The pharmacy's prescribing policies stated that all people supplied with weight loss medication should be reviewed at eight weeks. The pharmacy submitted evidence following the inspection to demonstrate that people receiving weight loss medication were being reviewed at eight weeks, irrespective of if they requested a repeat supply. The review involved a survey which was sent via an email instead of a two-way conversation, which could make it harder for the pharmacy to obtain more comprehensive information from people. The responses from the survey were collated and prescribers could request access to this information. But people's responses were not stored on the individual person's record, which may make it harder for the prescribers to review. People had the option on the survey to book a consultation with the customer service team or one of the pharmacists. A member of the customer service team said that they were responsible for gathering data on side effects reported by people and sharing this in the monthly meetings with the clinical lead and prescribers. They described how they had flagged up some side effects experienced with a weight loss medicine to the pharmacist, who had in turn contacted those affected to provide them with additional advice. Following the inspection, the clinical lead of the pharmacy provided 20 examples of clinical interventions made by the prescribers. But these types of

interventions were not routinely recorded on a person's individual consultation record. 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.

The RP clinically checked prescriptions once they were dispensed. People were provided with an information leaflet about how to take the medicines they were prescribed. People were informed if a certain medicine was being prescribed outside the licensed uses of the medicine via the pharmacy's website. Additional counselling information was printed on the medicine label, for example, when to take the medicine and if it should be taken with or without food. The pharmacy posted out medicines to people living within the UK as well as those in other countries such as Japan and Australia. The director said he had checked if the medicines could be sent to the relevant countries and had updated the pharmacy's indemnity insurance to cover overseas supplies. The pharmacy had stopped supplying to the United States of America.

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 director described how the company who supplied the temperature sensitive packaging had verified that the temperature was maintained. Uncollected packages were returned to the pharmacy. The director confirmed that any medicines that came back this way would be destroyed.

Medicines were obtained from licensed wholesalers. The pharmacy checked expiry dates of the medicines and maintained a record. 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. Drug recalls and alerts were received electronically, actioned, and documented. The pharmacy continued to prescribe off-license Ozempic for weight loss to people despite the national patient safety alert in October which informed pharmacies to prioritise this medication for those being treated for diabetes and to start replacing those taking Ozempic for weight loss with a suitable licensed product. Following the inspection, the pharmacy director informed the inspector that they would cease offering Ozempic off-license for the treatment of weight loss.

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

The electronic patient medication record system was password protected. Reference sources were available including access to the internet. Confidential waste was shredded. The pharmacy was closed to the public which helped to protect people’s confidentiality. It had suitable fridges to store temperature-sensitive medicines.

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.