

Registered pharmacy inspection report

Pharmacy Name: E Shop Pharmacy, Forward House, 14 Duke Street,
Macclesfield, Cheshire, SK11 6UR

Pharmacy reference: 9011960

Type of pharmacy: Internet / distance selling

Date of inspection: 23/07/2024

Pharmacy context

The pharmacy is on a parade of shops in the town of Macclesfield in Cheshire. People can access private health screening services and get travel vaccinations at the pharmacy in a clinic setting. The pharmacy provides a private online prescribing service through its website www.eshoppharmacy.co.uk for a range of conditions including for erectile dysfunction, acid reflux and emergency hormonal contraception. And it provides a range of health screening testing kits, including for bowel cancer screening, and a small number of pharmacy (P) medicines. It delivers medicines and health screening kits to people's homes.

Overall inspection outcome

✓ Standards met

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.1	Good practice	The pharmacy has good governance arrangements to support the safe delivery of its services. This includes detailed written risk assessments and policies to support the safe and effective delivery of services.
		1.4	Good practice	The pharmacy listens and responds well to people's feedback. It makes changes to the way it works to improve the safety and quality of the services it provides.
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	4.1	Good practice	The pharmacy responds to the needs of people accessing its services well. It focusses on person-centred care to support people with their health needs. And the team is good at communicating with people about their health and treatments.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy suitably identifies the risks associated with its services. And it is good at documenting how it manages these risks. It has up-to-date written procedures to help the team provide services safely. It proactively makes changes to its practice following feedback to improve its services. And the team learns from mistakes to reduce the risk of similar mistakes happening in the future. The team keeps people's private information secure. And it helps protect the safety of vulnerable people through the decisions it makes about how people access its services.

Inspector's evidence

The pharmacy provided health screening services for people, including taking blood tests on site. It had recently started a travel vaccination service, administering vaccinations, including Hepatitis B vaccinations, using patient group directions (PGDs). The PGDs were held in the pharmacy, signed and up to date. People completed a health form and signed to consent for the vaccinations. The pharmacy provided a private online service through its website supplying prescribed medicines through an online questionnaire consultation. The consultations were reviewed by one of the two pharmacist independent prescribers (PIPs) who worked remotely. It sold a small number of Pharmacy (P) medicines through its website, using a questionnaire-based model. The pharmacy had standard operating procedures (SOPs) relevant to its services and these included for dispensing, Responsible Pharmacist (RP) Regulations and the process to contact patients following consultations. From the sample checked, the SOPs were up to date and had been written by the superintendent pharmacist (SI) over a range of dates from 2022 onwards. The training record sheets were signed by the current team members. The pharmacy had a business continuity plan dated 2022.

The pharmacy had written risk assessments for the treatments it provided, and a further risk assessment had been completed when introducing a new treatment option, for example for injectable weight loss medicines. The pharmacy had considered the risks associated with providing these medicines including the delivery of medicines requiring cold storage and how to manage risks with providing these treatments through its online private prescribing service. The risk assessment detailed the mitigation required of how to independently verify a person's answers to the online questionnaire, including their weight and height, and what processes to follow to ensure the medicine was suitable to supply to the person. The actions included using a recognised ID verification service as part of the online process to obtain photographic ID. And to obtain full length photographs as part of the consultation to support the medical online questionnaire. To communicate with the person's GP, the pharmacy had used an online communication platform for NHS providers, and the pharmacist demonstrated an example of a GP's approval for treatment using this platform. However, access to this platform had been stopped. The pharmacy had reviewed the risks of providing the service, and decided to suspend providing the service to people wanting to start treatment until an alternative way was found to gain GP approval or independently verify people's information.

The pharmacy's risk assessments detailed maximum quantities, frequency of supplies and age range for each treatment. There were documented inclusion and exclusion criteria for each treatment. Decisions had been agreed between the SI and prescribers. And they used evidence-based national guidance, including the National Institute for Health and Care Excellence (NICE) and British National Formulary (BNF) guidance. The prescribed maximum quantity for omeprazole had been reduced following a

clinical review of guidelines. From the prescriptions checked, these policies were adhered to, for example for omeprazole and erectile dysfunction medicines such as sildenafil.

The pharmacy had completed a small number of audits of its services, including one for rejected orders. And it completed reviews after incidents, for example after medicines were delivered to an address not specified by the patient. The last formal audit had been in August 2023, and the pharmacy hadn't completed any clinical audits of prescribing against its policies or after introducing new treatments. The pharmacy had a paper near miss error log, with one entry in the last year. Near miss errors were mistakes identified before the person received their medicines. The SI reported few near miss errors happening but agreed that the near miss error log should be checked and annotated monthly to confirm no near miss errors had occurred. There was a SOP detailing how to manage near miss errors and dispensing incidents, which were errors identified after people received their medicines. And there was a form to record dispensing incidents, with details of how to report incidents to the NHS 'learn from patient safety events' (LFPSE) service.

The pharmacy had responded to people's feedback and implemented changes to ways of working. This included changing the website layout for repeat prescriptions following feedback from people using it. The pharmacy had mainly good feedback on a recognised online review site, and it had responded to the one piece of negative feedback detailing delivery to an incorrect address. And it had changed its prescription template to add in an additional check of the delivery address, to prevent it happening again. Following feedback about test results going missing at the lab, the pharmacy had reviewed the reason for this, identifying a required form had not been sent on several occasions. Following this the SI introduced a series of changes to help people understand the requirement to complete and send the form with their test to the lab. After each change the success of the change was reviewed until the level of missing tests reduced to a minimal level.

The team working at the pharmacy premises held a variety of roles, for example supporting with reception duties, accounting, and phlebotomy work. The staff were clear about their roles and responsibilities. They didn't support with any dispensing tasks. They were seen completing tasks according to their role and referring all pharmacy queries to the SI. The SI, who was working as the RP, displayed their RP notice. The RP SOP detailed a matrix of roles and responsibilities for the team to refer to if needed. The pharmacy had current professional indemnity insurance, covering the services provided. It didn't supply any controlled drugs (CDs) and didn't have a CD register. The pharmacy held its private prescription records electronically within the patient medication record (PMR) system and the records seen contained the required details. The RP record was mostly completed accurately, apart from an incorrect date entered on the day of the inspection, which was rectified.

The pharmacy displayed a privacy notice on its website, detailing how it managed people's data. And the team was aware of maintaining people's privacy for example they understood how important it was not to enter the clinic room during consultations. Confidential waste was separated and removed for destruction by a third-party contractor. There was a printed copy of GPhC guidance on confidentiality to refer to. The pharmacy had a safeguarding policy. The SI and a trainee dispenser had completed safeguarding training relating to vulnerable adults and children. The pharmacy only supplied emergency hormonal contraceptives to the patient and not a representative, even though RPS Guidance detailed that in certain circumstances this was appropriate. The SI had assessed the risk of online supplies to vulnerable people and documented the decision in the risk assessment.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy manages the workload effectively and staff provide services safely and efficiently. They keep their knowledge up to date and relevant to the services they provide. And they make clinical and professional interventions to support people's care.

Inspector's evidence

The SI was the RP on most days the pharmacy was open, but recently a locum pharmacist had worked at the pharmacy to help provide business continuity for when the SI was not working. Currently the SI dispensed and checked most prescriptions, although a part-time member of the team, not present for the inspection, was enrolled on an accredited dispensing qualification course to provide support. There were two other members of staff on the premises during the inspection and their roles did not require accredited training. People came to the clinic mainly for health screening testing and appointments were made electronically to help manage workload. Dispensing activity was up to date, and the dashboard showed a couple of tasks awaiting action for the prescribers rather than activities for the pharmacy.

The SI demonstrated how prior to considering a new service they assessed any training needs. They had recently started a travel vaccination service, providing this through PGDs. The SI felt they would benefit from additional training in vaccination techniques and had attended training in London to meet these needs. A certificate of completion was on display. The SI confidently spoke about the different health screening tests provided by the pharmacy, NICE recommended guidelines associated with treatments, and treatment options for a positive test result. The trainee dispenser had completed some training associated with safeguarding and had read the SOPs and another colleague had completed training associated with her role in phlebotomy. The SI communicated well with other colleagues and was in close contact with the prescribers working for the pharmacy's online prescribing service. The SI described how decisions about treatments and refusals to prescribe were discussed with the prescribers and they appeared to have a good, open working relationship with them. The prescribers were pharmacist independent prescribers, working in general practice. The SI described how checks were made to make sure treatments offered were agreed with the prescribers to be within their areas of experience and competence. The SI held team meetings and was open to listen to ideas to improve services. There was a written procedure about whistleblowing. The pharmacy set no targets for services.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are secure, clean, and suitable for the services provided. The pharmacy's website is professionally laid out and easy for people to use.

Inspector's evidence

The pharmacy premises were secure, clean, hygienic, and provided a professional image for people accessing care from the premises. The reception area was clean, modern, and bright with ample seating for people waiting. The clinic room was directly off reception and fully soundproof, secure, and of a good size for the services provided. The pharmacy was well lit and of a suitable size with enough bench and storage space for the workload. And it kept benches and floor areas clear from clutter. There was a fire door upstairs that automatically closed in the event of a fire and there were fire exit signs. There was access to toilet facilities and hot and cold running water.

Pharmacy services were offered through its website, which was professionally laid out with relevant information about conditions and treatments offered. The pharmacy's contact details and details about the SI and prescribers were available on the website. People completed a consultation questionnaire which started at the website condition page and met current GPhC guidance. People submitted the answers to the questionnaire prior to receiving information as to whether treatment was appropriate for them. This reduced the risk of people making changes to their answers. The website displayed the pharmacy's telephone number giving people an option to speak with someone about treatment rather than completing the questionnaire.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages and delivers its services safely and effectively. And its focus is on person-centred care. It makes considered decisions about the medicines it supplies. And it is good at making its services accessible and communicating with people about their health and treatments. The pharmacy gets its medicines and testing kits from recognised sources. And it stores and manages them as it should.

Inspector's evidence

People accessed some of the pharmacy's health screening services and travel vaccinations face to face in a clinic setting. There were steps up to the entrance to the pharmacy, with a handrail to help people access the premises. There were seats within the reception area. Its services were advertised in the window. The private online prescribing service and some health screening kits were accessed from the pharmacy website www.eshoppharmacy.co.uk. This included for bowel cancer faecal immunochemical test (FIT) kits and sexually transmitted infection (STI) testing kits for chlamydia and gonorrhoea. The pharmacy had two associated websites www.allcheckedup.co.uk and www.eshophealth.co.uk mainly for health screening kits and also for travel vaccination bookings. The pharmacy linked the supplies of treatments and health screening kits to promote a more complete service. For example, if a test result showed a positive result for H Pylori, then the person was offered the recommended antibiotic treatment through its online prescribing service. And they were offered a repeat test. If following treatment, the result was positive, the SI described how people were referred to their usual prescriber for further investigation and treatment.

The private online prescribing service was accessed by completing a consultation questionnaire on the pharmacy's website. If people preferred, they could go through the questions on the telephone with the pharmacist and this was advertised on its website. The SI gave examples of people who preferred to speak with the pharmacy team and examples of correspondence by email. The pharmacy provided medicines for a limited range of conditions, according to the prescribers' experience and competency. It supplied a small range of P medicines on its website, for example hormonal replacement vaginal tablets. It followed the same process for P medicines as for prescribed medicines, in that people completed an online questionnaire on the pharmacy's website. The requests for P medicines went to the RP, usually the SI, to check for suitability and authorise. They demonstrated the checks made and examples of refusals to supply when the person did not meet the criteria, for example, when a person didn't have menopausal symptoms as per the licensed indication for Gina vaginal tablets.

The pharmacy used a recognised ID verification system, and if people didn't pass the first verification, then there was a second facial recognition verification used. Once questionnaires were submitted, prescribers were alerted to the request. The prescribers worked remotely and had unique logins and two factor authentication to access the system. This allowed the submission of a valid electronic prescription, which was only accessible to the pharmacy after the prescriber had authorised it. There were three different levels of access to the system, prescriber, pharmacist, and an administration role and team members could only access to complete tasks suitable for their role. The pharmacy and prescribers regularly communicated with people either by email or on the telephone to ask questions and to clarify details submitted on the questionnaire. Records of these emails were kept on the system in case of queries and as an audit trail. The pharmacy had several template emails to send to people,

providing advice and further information about their treatments and results from their tests. And it supplied a range of bespoke in-house information leaflets with medicines and testing kits to help people understand their treatment and the benefits of testing. If emails relating to test results went unanswered the pharmacist telephoned the person to ensure they had received their results and to discuss any next steps. If the person was at high-risk then the pharmacist contacted the person's regular prescriber themselves. They described how they had signposted a person to an emergency walk in centre providing them with a letter of the test results. For some treatments, such as for weight loss, the pharmacy contacted the person's regular prescriber before treatment was initiated and it recommended for all treatments that people informed their regular prescriber. But it didn't directly inform them of the treatments it supplied. Clinical information such as test results and Body mass Index (BMI) was recorded on the system for prescribers and pharmacists to use as part of their decision making and clinical check. They also saw the person's previous dispensing history. From a sample checked people's BMIs were within the range appropriate for treatment. The prescribers and SI communicated by an instant messaging application about queries on prescriptions and when prescribers refused a request. But the pharmacy didn't make records of these interventions. And the prescribers didn't make notes on the system to record the decisions as to why treatments were suitable or not for the person requesting them. Following the inspection, the SI confirmed the system had been changed to add a consultation notes section for the prescribers to complete before approving or refusing a person's treatment, so there was record of decisions going forward.

The layout of the dispensary helped minimise errors using workstations for labelling and processing of prescriptions and there was sufficient bench space to dispense and complete accuracy checks safely. Prescriptions were printed along with the shipping labels and the shipping address was printed at the bottom of the prescription so that the accuracy of the delivery address was checked as part of the final dispensing check. Any test results were also printed and attached to the prescription to ensure clinical information was available when checking prescriptions. The pharmacy followed safe working practices when dispensing, including using different coloured baskets. This helped prevent different people's prescriptions and orders from becoming mixed up. Pink baskets were used for female patients and blue baskets for male patients. This helped the pharmacist check the suitability of the medicines according to the gender of the person. The pharmacy didn't supply any controlled drugs or higher-risk medicines such as valproate. It used the postal service to make deliveries to people and it had the facility to track orders to help investigate delays and missing packages. When items had been checked they were sealed in discreet packaging and stored in sacks awaiting collection by the postal service. Specialised packaging, including cold packs, was used for medicines requiring cold storage. The suitability of the packaging had been checked by the SI. These items were delivered using an upgraded postal option to guarantee next day delivery.

The pharmacy obtained medicines from recognised wholesalers. It used United Kingdom Accreditation System (UKAS) registered laboratories for test results and the SI had checked the accreditation covered the specific tests it sent there. The pharmacist securely accessed the test results. The pharmacy stored its medicines and health testing kits in lockable cabinets in the dispensary. Some additional stock was stored neatly in a separate storeroom. The pharmacy completed a check of expiry dates every two weeks and recorded the expiry dates of medicines on the inside of the cabinet doors. There was no formal date checking matrix and the dates the checks were made were not recorded. All medicines and testing kits checked were within their expiry dates. The pharmacy stored medicines requiring cold storage neatly, in a small medical fridge and kept a daily record of fridge temperatures which showed temperatures to be within the correct range. A third-party contractor removed pharmaceutical and clinical waste. The pharmacy received email notifications of medicines recalls and safety alerts. The system tagged these alerts to be read by the pharmacist. Once read, they made an electronic note of the action taken and the date which provided an audit trail.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And it uses its equipment appropriately to protect people's privacy.

Inspector's evidence

The pharmacy had the equipment it needed for its services, including a suitably sized medical fridge, cool packs stored in a freezer and sharps bins in the clinic room. The manufacturer had confirmed that the packaging and cool packs used for delivery of fridge lines kept the medicine within the required temperature range for 72 hours. The team used discreet packaging with strong seals suitable for delivery by the postal service.

The pharmacy had reference resources, relevant to its services and access to the internet for up-to-date information. It had password-protected computers with unique logins for prescribers. And it restricted access to the premises so unauthorised people couldn't view confidential information. The pharmacy stored people's medicines awaiting delivery in the dispensary until the postal service picked them up.

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.