General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LetterBoxPharmacy.com, 20 Spelman Street, London, E1 5LQ

Pharmacy reference: 9012021

Type of pharmacy: Internet / distance selling

Date of inspection: 04/12/2024

Pharmacy context

This pharmacy is located in a residential area near Whitechapel, London. It provides services at a distance and through appointments. This includes NHS services such as dispensing prescriptions, the New Medicine Service (NMS), flu vaccinations and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to people who need this support to manage their medicines at home. And it provides a delivery service. It also offers a private prescribing service and some other private services including travel vaccinations and ear wax removal.

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	1.2	Good practice	Team members record and regularly review their mistakes and demonstrate how they use team discussions to improve patient safety and quality of the services they provide
2. Staff	Standards met	2.3	Good practice	The pharmacy team keeps records of interventions that have had positive outcomes for patients and uses these as a point of discussion and learning in their regular meetings.
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 manages the risks associated with its services. It uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. People using the pharmacy's services can easily provide feedback. Team members protect people's information well and have the relevant training to safeguard the welfare of people using their services.

Inspector's evidence

Standard operating procedures (SOPs) were available in the dispensary for the team to refer to if required. They had been reviewed in 2023 with the next review due in 2025, and team members had signed them to show that they had read and understood them. When asked, team members were clear about their roles and knew when to refer to the responsible pharmacist (RP). They knew what activities could and could not be done in the absence of an RP.

The superintendent pharmacist (SI) was the RP on the day of the inspection, and the RP notice was correct and visible. The RP record was held electronically and was mostly complete. Documentation for unlicensed medicines supplied and private prescription records were well maintained, and records for emergency supplies contained the nature of the emergency. A random physical check of three controlled drugs (CDs) showed the quantities matched the balance recorded in the register. Checked prescriptions for CDs were bagged and stored separately inside the cupboard. The SI was aware of the need to contact the local Controlled Drugs Accountable Officer to obtain authorisation for destruction of any expired medicines.

The pharmacy had records available, documenting the dispensing mistakes that had been identified before reaching a person (near misses). Informal discussions with the pharmacist were had at the time the mistake was made to address any feedback and generate ideas to prevent future mistakes. And a regular monthly review where any learnings, trends or patterns were identified was completed with the whole team. Actions that had been identified during the review were listed at the bottom of near miss record. The SI showed that a few medications with different strengths or those that looked alike, had been separated in the dispensary and stickers were used on the shelves to further highlight this, demonstrating some action taken to minimise mistakes. And workbenches were labelled to separate dispensing activities where possible. The director, who was also a qualified dispenser, said that in the past the pharmacy had experienced a dispensing mistake which had reached the person (dispensing error). They explained that staff escalated any errors to the director and the SI, and described the actions they would take, including speaking to the person who was impacted by the error, retrieving medications to make any necessary corrections, reporting to the GP where required and discussing with the team members involved to establish learning and prevention. There was an SOP available for dealing with dispensing errors which included the 'learn from patient safety events' (LFPSE) service details to ensure any errors were reported to the national system.

The pharmacy provided a prescribing service for a range of conditions such as minor ailments, weight management services, and hayfever (Kenalog). The pharmacy had prescribing SOPs for the areas that the pharmacist independent prescriber (PIP) was prescribing for. And a pathway for remote prescribing was in place to ensure consistency of practice. The prescribing document for Kenalog was detailed with inclusion and exclusion criteria for treatment, a list of symptoms for differential diagnosis and points for

counselling including side effects and safety netting. The weight loss prescribing guidelines seen briefly outlined assessment, dosing, counselling, and monitoring, but did not reference what guidance was followed. Guidelines were seen for Rybelsus but counselling around off-label use (outside the scope of its product licence) was not documented. Guidelines for the weight loss treatments were not dated and this may mean that they were not updated appropriately in line with national guidance.

A risk assessment was in place for offering services at a distance and addressed risks and mitigation associated with this, such as limited physical examination, identity checking and documentation. The risk assessment did not mention consent; however, evidence of consent forms for prescription nomination, and in service questionnaires for treatment and information sharing was seen during the inspection. And regulatory guidance was printed for reference alongside the risk assessments.

The pharmacy could not produce records of consultations with people on the day of inspection. The PIP and doctor with prescribing oversight were the only team members who had access to this system for confidentiality. Initial information gathering through questionnaires for the weight loss service were seen during the inspection. These contained consent for treatment and information sharing, history of medications, diagnosed conditions and lifestyle. Example consultation records with follow up documentation and doctor review notes were seen following the inspection. This included information and advice provided on lifestyle, medicines given and monitoring. Evidence of information sharing with a person's regular prescriber was also seen. The consultation records did not include key points on which the decision was made to supply or refuse a medicine. This may mean that the prescriber did not have all the information required to justify prescribing decisions.

The director said that they had not yet completed an audit for the prescribing services offered due to the low number of prescriptions they had processed. They said that they planned to do these monthly moving forward to assess the appropriateness of prescribing and to identify areas for service improvement.

Current indemnity insurance was in place. Feedback or complaints from people using the pharmacy's services could be received, via telephone, email or through the pharmacy's website and online review sites. If a complaint was received, team members could escalate issues to the SI and director, and there was a complaints procedure they could refer to.

The computers were password protected meaning that confidential electronic information was stored securely, and confidential paper waste was shredded on-site. Medicines awaiting collection by the delivery drivers were stored out of sight by anybody attending the pharmacy for appointments. Team members had completed data protection training and an information governance policy was in place for reference. They understood safeguarding requirements and were able to describe some of the signs to look for and the actions they would take to safeguard a vulnerable person. There was a safeguarding policy in place and team members had completed training and were aware how to refer to safeguarding authorities if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff for the services it provides and manages its workload safely. The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open environment.

Inspector's evidence

The team present during the inspection consisted of the SI, the director, an accuracy checking pharmacy technician, two qualified dispensers and one trainee dispenser. All team members were qualified or enrolled on accredited courses, including delivery drivers. The director explained that locum staff were employed for business continuity when required to cover any pharmacist absences.

The SI said they felt comfortable in using their professional judgement when decision making. The team was up to date with dispensing prescriptions with no backlog of workload. And team members were able to demonstrate an awareness of medicines with the potential for misuse and could identify people making repeat purchases. They knew questions to ask when selling medicines or providing advice and knew when to refer to the pharmacist. The team also kept a monthly record of any interventions they had made. These included adverse events that people had reported, such as allergies to medications and action that had been taken for example reporting this to the persons GP. Other examples included where medicines had been inappropriately prescribed, including one where the dosage of a medicine had been too high for a child.

Team members had a yearly appraisal, and when asked, team members felt able to raise concerns with the director and SI and described working openly as a team. The team had regular structured meetings to raise any concerns and put forward ideas. The meetings included the review of the near miss record, a section on any clinical learnings from interventions they had made, any updates to SOPs and any feedback from people using their services. The team gave examples of changes that had been made in response to their feedback. This included the introduction of the delivery software used to ensure that they had a robust audit trail for deliveries that left the pharmacy. They also decided due to the limited space in dispensary, to prioritise dispensing prescriptions when all the stock was available, unless there was an urgent request. There was no structured process for ongoing development of the team. However, they were able to access online training resources in work hours and discussed any new products, services, or learnings together. Team members had the opportunity to progress through different accredited courses. Certificates were seen for the PIP in the areas where prescribing services were offered.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it has adequate space for providing its services safely. The pharmacy premises are also safe, secure, and appropriately maintained.

Inspector's evidence

The front door to the pharmacy was kept locked and people could ring a doorbell for access. There were a few steps up to the pharmacy entrance that led to a seating area and payment counter, with pharmacy-only and general sales list medicines displayed behind it. The director explained that people usually purchased these medicines via telephone after consulting the RP and they were sent a link to pay, however they allowed some people to come in and pay if they could not use the link. There was a small corridor that led to the consultation and treatment room, and further on from this was a small staff kitchenette. The dispensary was in the basement of the property and had suitable lighting and the temperature was appropriate for the storage of medicines. A clean sink was available in the dispensary for preparing medicines. And hand washing facilities were available in the consultation room and in the kitchenette. Team members had a cleaning rota to maintain the pharmacy.

The pharmacy's website contained details about the superintendent pharmacist and the pharmacy's location and contact details. Links to check the registration status of the pharmacy and SI were displayed, and the website had a 'feedback and complaints page'. Other links were available to access the pharmacy's privacy policy, and terms and conditions. However, some of the website was not yet completed, for example, links for services at the bottom of the main page led to a lifestyle questionnaire which was not treatment specific. This may mean that people were providing irrelevant or unnecessary information prior to consultation. During the inspection, the director commented that the website was in the process of being updated. And other website tiles for services were seen to be working with treatment-specific questionnaires.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, to a range of people with varying needs. It obtains its medicines from reputable sources and stores them properly. It takes action in response to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to use. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely.

Inspector's evidence

The pharmacy offered services by appointment only, and signposted people to other nearby pharmacies where necessary. The entryway to the premises had a door large enough for people with wheelchairs and pushchairs. There were a few steps into the pharmacy and the SI said that was a ramp available if required, and staff helped people gain access where needed. Large-print labels were available on request, and all team members were multi-lingual, which allowed them to be accessible to the demographic of people in the surrounding area. The pharmacy offered the Pharmacy First service under patient group directions (PGDs) and these were printed in a folder for reference and signed by the SI and the locum pharmacist who covered absences. Valid private PGDs were also signed and available for reference. The pharmacy mainly received referrals for pharmacy first services from local GP practices, but people could self-refer if required. The SI said that if a person did not meet the criteria for treatment, they emailed the GP with the information and details already gathered to help them to quickly triage the person. A poster was displayed in the treatment room to make people aware of the private and NHS services offered.

Medicines were sourced from licensed suppliers. Expiry date checks were carried out routinely and a current date checking matrix was seen during the inspection. A random spot check of stock revealed one expired medicine, this was put with the medicinal waste for destruction when brought to the team's attention. A highlighter pen was used to mark the short-dated items. And dates of opening for liquid medicines were seen to be written on the bottles for staff to know if they were still suitable to use. Temperature records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy's email. Emails were checked by team members daily and any alerts were printed and kept in a folder to maintain an audit trail of the actioned alerts.

Team members were observed following the SOP for dispensing prescriptions and baskets were used to keep items for different people separate. Dispensing labels included 'dispensed by' and 'checked by' boxes to indicate who had carried out those tasks. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. Packs were assembled in a designated area in the dispensary to help avoid distractions. The processed was managed by allocating people into weeks. The pharmacy used this system to organise ordering repeat prescriptions for people, to help ensure they were ordered in a timely manner for dispensing. The pharmacy technician said that they contacted the surgery if there were any items missed or any changes made to a person's regular prescription, and these were documented on the patient medication record (PMR). Examples of interventions for these people were seen during the inspection

and the pharmacy utilised the NHS discharge medicines service to check when someone had any changes to their medicines when coming out of hospital. Medicine warnings were printed on some of the backing sheets inside of the packs, but not all. The pharmacy technician changed the settings on the PMR system during the inspection to ensure warnings are printed where necessary going forward. Descriptions of each of the medicines were also printed on the sheets and patient information leaflets were provided with each supply.

Some of the private prescriptions that the pharmacy processed were received through a third-party service, which were to be supplied to an aesthetics practitioner for administration to a named person. For these prescriptions the pharmacy contacted the named person who would be receiving the medication for consent to access the NHS summary care record, so that clinical checks could be performed. The pharmacy also contacted the prescribers directly when there was missing information such as patients body mass index (BMI) when weight loss medication was prescribed.

The director explained that for the weight loss service, people booked an initial face-to-face appointment where a starting weight, height and blood pressure reading were taken, as well as to obtain consent for access to the NHS summary care record. People were also asked to complete a questionnaire during this appointment and identification was checked. The PIP then contacted these people via video link for a full consultation, the director said that if the PIP felt it necessary then another face-to-face appointment could be scheduled. The director explained that for the weight loss service consent to provide information to a person's GP was obtained, and if consent could not be obtained then treatment was not provided. On initiation of treatment, a printed aftercare guide was supplied to each person. This had information on administration of the medicine, common side effects, red flags and when to seek medical intervention, and contact information of the pharmacy.

The pharmacy offered a delivery service and had designated delivery drivers for this. All deliveries were made within the pharmacy opening hours and a detailed audit trail of what deliveries had been made was kept. The pharmacy used a system where a QR code was printed on a label and the drivers scanned this when collecting from the pharmacy and again when it was delivered to a person. Team members could access the system to see what medications were on route, had been delivered, or if there was an unsuccessful delivery, to aid in addressing any queries. The system highlighted if there was a fridge or CD medicine in the bag so that deliveries could be prioritised accordingly. And stickers were also used on the bags to further highlight this. The pharmacy technician said that insulated packaging was used for fridge medicines. Medicines were returned to the pharmacy if people were not home, and the pharmacy had cards to post through people's doors and contact numbers to reschedule where necessary. The pharmacy used a 24 hour or next day courier service if deliveries were further away.

When asked, team members were aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. Leaflets were available to give with dispensed valproate products. The importance of undertaking individual risk assessments if valproate was not dispensed in the original manufacturer's pack was discussed with the SI who gave assurances that this would be completed where appropriate if they had people requiring valproate in their compliance packs. Prescriptions for other higher-risk medicines were highlighted by the PMR system when dispensing and a label was printed to highlight them, as well as any interactions. The SI kept a record of each person he had spoken to in regard to their higher-risk medicines to ensure that opportunities to provide counselling to people about these medicines was not missed. Cytotoxic medications were also separated on the shelf so that team members were aware when dispensing these.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment to provide its services safely. And it protects people's privacy when using its equipment.

Inspector's evidence

The pharmacy used standardised conical measures for measuring liquids and clean triangle tablet counters were available for dispensing loose medication. A separate triangle counter was available for certain substances that were marked to avoid cross-contamination. A digital otoscope with disposable specula covers was available for providing ear wax removal services, the director said this was sent to the company every two years for maintenance. There was an ambulatory blood pressure monitor and a standard blood pressure monitor in the consultation room, the director said that these were new and would usually be replaced or calibrated annually. An adrenaline auto-injector and sharps bin were stored in the consultation room for when vaccinations were being administered. Body weight scales were also available. A portable telephone enabled the team to ensure conversations were kept private were necessary. All computers were password protected to safeguard information.

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.