General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmica, 236 Gray's Inn Road, London, WC1X 8HB

Pharmacy reference: 9012030

Type of pharmacy: Internet / distance selling

Date of inspection: 28/06/2024

Pharmacy context

This is an internet pharmacy in central London. It offers services through its website www.pharmica.co.uk. It does not provide any NHS services. And people who use the pharmacy do not visit the premises in person. They can access a prescribing service which offers prescriptions for a range of conditions. The prescribing service is provided by pharmacist independent prescribers (PIPs). The pharmacy mainly supplies medicines to people living in the United Kingdom (UK) and aged 18 years of age and over.

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 written risk assessments (RAs) and prescribing policies for the medicines it provides to manage the risk associated with providing online pharmacy services.
		1.2	Good practice	The pharmacy reviews the risks associated with medicines to make sure supplies are appropriate and services are safe.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members are encouraged to complete learning and training to keep their skills and knowledge up to date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy's services are supported and managed through team training, procedures and audits to deliver them safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages the risks in providing its services appropriately. It has suitable written instructions to help its team members to work safely and effectively. It routinely audits its online services to monitor their safety and quality. Members of the team understand their roles and know what they are responsible for and when they might seek help. People who use the pharmacy can leave feedback to help it do things better. The pharmacy keeps the records it needs to by law to show how it supplies its services and medicines safely. The pharmacy team keep people's private information safe and they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy offered an online prescribing service through its website. It offered treatments for men's health, women's health, general health, respiratory and digestive, travel and skincare. And the quality and the safety of the prescribing service was regulated and inspected by the General Pharmaceutical Council (GPhC). The prescribing service was provided by pharmacists who worked remotely and split the working week between them. The people who could access the services were aged over 18 and based in the United Kingdom (UK). The pharmacy had written risk assessments (RAs) and prescribing policies for the medicines it provided. These were written, signed and generally reviewed by the superintendent pharmacist (SI) every two years or earlier if there had been an incident. The pharmacy had reviewed the risks associated with the types of medicines it could supply. And it had decided it would not introduce a medicine that could lower a person's blood pressure as a result of attempts by people to obtain and use the medicine inappropriately. And it proactively discontinued other medicines such as antibiotics, due to the risk of contributing to antibiotic resistance within the community.

Following a review of a National Patient Safety Alerts that was issued during 2023, the pharmacy did not supply 'off-label' weight-loss medicines which were usually used to treat people with diabetes. It did not supply any controlled drugs (CDs), or medicines which required monitoring. Asthma was the only long-term condition for which limited treatment was available to the people. In line with the pharmacy's policy, it requested and encouraged people seeking treatment to provide their regular GP's details to confirm diagnosis. If there was a genuine reason for not supplying GP details, the pharmacy restricted the amount of medicine the person could have and sent them a guidance email to emphasize why it was important to inform their GP as a safeguard in the management of their treatment.

Online medicines assessments (MAs) were available for each medicine and stated the maximum quantity people could request. MAs included selecting medicines online and completing the medicines assessment which went to the pharmacist independent prescriber (PIP) for the clinical check and issuing a prescription. When people were completing the assessment, they were unable to see the score and then adjust the answer. If there were inconsistencies in the responses or they had been changed, the prescriber could hold off an order and request more information by phone or email. People could be contacted via phone, live chat, email, SMS or call back services. The pharmacy had a screen showing orders on hold pending further information. For example, a team member explained why an assessment to obtain a salbutamol inhaler had been cancelled. The person's answers indicated that the

condition was not controlled. This was further endorsed during a call to the person whose answers to questions increased concern. The team member explained to the person why the supply was refused. The pharmacy team member was able to provide other examples of orders being cancelled. For instance, a person did not respond to a request for an identification (ID) check, so the order was cancelled. On the next order, ID was requested again and it was then sent by the person. Records of any interactions with customers were made routinely. There was also an interventions log recording when the off-site prescriber had been contacted with a query. During and after the visit, the pharmacy team was able to provide multiple examples of interventions they had made in requests for asthma treatment, how they were resolved and whether an inhaler was supplied.

When people created an account, they had to provide proof of identity which could be a driving license or passport. And the pharmacy also used a third-party verification system. People could sign up to a subscription on some conditions such as erectile dysfunction (ED), to avoid running out of medicine. The pharmacy team verified the identity of every person to minimise multiple accounts, supply limits being exceeded, or where gender had to be confirmed. Identity verification was mandatory for all orders, specified for each treatment outlined in the risk register.

People could not add any treatment directly to their basket and were directed straight to a consultation. New orders were cross-referenced with previous orders for the same person. A record of consent was maintained. Prescriptions and orders were prepared on the pharmacy's premises. The pharmacy team could see the person's records if required. People had to complete a new MA each time they wanted to order a medicine. If the pharmacy team needed to check an interaction, they could contact the prescriber via 'Slack'. And the outcome was recorded. The pharmacy had a business continuity plan to deal with providing services in the event of a systems failure. And it included access to an electricity generator.

The pharmacy completed clinical audits on a monthly basis such as supplies of pharmacy only (P) and general sales list (GSL) over-the-counter (OTC) medicines and treatment ranges of prescription only medicines (POMs). The pharmacy was able to produce examples of prescribing audits and the risk assessment register. Following analysis of findings of an audit of prescribing quality of certain medicines, the pharmacy team decided to provide extra counselling for a particular medicine and introduced a system alert to highlight orders for the medicine. The IT development team added a feature to facilitate audits by filtering information.

People shared their views online about their experiences of using the pharmacy. The pharmacy monitored live chat for feedback. It had a complaints procedure and there was a customer service team to help people too. And the website told people how they could provide feedback about the company or its services.

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed regularly. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and agreed to follow them. They knew what they could and could not do, what they were responsible for and when to ask for help. And they understood their roles. A team member explained that they would not assemble or dispatch prescriptions if the pharmacist was not present. The pharmacy had processes to deal with the near misses that were found before the order left the pharmacy. And for dispensing mistakes that reached the person. The pharmacy team reviewed and recorded the mistakes it made to learn from them and help stop the same type of mistakes happening again. The team discussed mistakes and shared learnings at patient safety (PS) meetings. If the team had to refer to the prescriber about a prescription, an audit trail was created with a record of the outcome, date and time of the intervention. The pharmacy advertised its services via its website.

The pharmacy team had produced a detailed risk assessment for each medicine available to purchase on the website including mitigations for each risk identified. It worked to prescribing SOPs and policies. It did not supply unlicensed medicines, stock any controlled drugs or make emergency supplies of medicines. The pharmacy displayed a notice that identified who the responsible pharmacist (RP) was and kept records to show which pharmacist was the RP and when. It kept records of the private prescriptions it supplied. And prescribing records were maintained on the patient medication record (PMR) system. The pharmacy team monitored fridge temperatures. The MHRA drug alerts and recalls were actioned and records maintained of affected stock.

The company was registered with the Information Commissioner's Office. A privacy notice on its website told people how their personal information was gathered, used and shared by its team. And the pharmacy had arrangements to make sure confidential information was stored and disposed of securely. The pharmacy was compliant with Payment Card Industry Data Security Standard (PCI DSS). Members of the team had a level of access to the pharmacy computer system which was appropriate to their roles. They were required to complete training on data protection. The pharmacy had a detailed information governance policy, which had been read and signed by all team members. They had completed safeguarding training provided by Interactive Healthcare Training. The pharmacists were trained in level 3 safeguarding. And members of the team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. They were able to describe a scenario which they had identified and dealt with when someone had made multiple attempts to purchase one particular medicine.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage their workload and deliver services safely. They are suitably qualified or in training to have the appropriate skills for their roles. And the pharmacy supports them with ongoing training to keep their knowledge up to date. The pharmacy's team members feel able to provide feedback to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team included the superintendent pharmacist (SI), three pharmacists, two pharmacist independent prescribers (PIPs), one pharmacy technician, twelve dispensing assistants who were full-time or part-time, four packing assistants and a weekly cleaner. The pharmacy team also provided customer service. There was a team who provided technical support managing stock but had no part in dealing with the customers or supplying medicines.

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Members of the pharmacy team worked well together so they were up to date with their workload. Team members completed mandatory training during their employment. New starters were trained in topics in an induction list managed by the pharmacy manager. Along with training in SOPs, team members were enrolled on courses including Safeguarding vulnerable people and Deprivation of Liberty, The Mental Capacity Act, Information governance and GDPR.

They were also required to do accredited training relevant to their roles after completing a probationary period. Much of the product training was conducted by pharmacists on-site during a team member's induction. And team members were encouraged to familiarise themselves with the products and to seek any further clarification they may require.

They discussed their performance and training needs during their annual appraisal. The pharmacy team was provided with ongoing training which included knowledge of new medicines, safeguarding and data protection. The pharmacy maintained training records for each team member. Team members were supervised and supported by the dispensary manager. The PIPs expanded their competencies in prescribing for which there was a formulary, and they were required to complete prescribing and peer review. The pharmacy produced examples of peer review regarding clinical knowledge in response to completed MAs.

The pharmacy team members discussed patient safety incidents and shared learnings from the mistakes they made at patient safety meetings. The team had a 'huddle' each day to allocate tasks and work streams. The SI was required to keep their professional skills and knowledge up to date. The pharmacy had a whistleblowing policy. It did not set targets for its pharmacy team. And it did not incentivise its services. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver its services from and it is clean, bright and secure. The premises are suitably secure to protect the pharmacy's medicines stock and people's private information when the business is closed. The website displays all the relevant information to meet GPhC guidance for registered pharmacies providing services at a distance, including on the internet.

Inspector's evidence

The pharmacy's registered premises were in an office block. They were secure, clean, tidy and presented a professional image. They were air-conditioned, bright with natural and artificial light. And only accessible to authorised personnel. The pharmacy was spacious. The premises were divided into areas allocated to different parts of the business. So there were areas dedicated to dispensing and packing, customer service, technical support and a break-out space where the team members could eat or relax.

The website www.pharmica.co.uk clearly set out information such as how to check the pharmacy's GPhC registration and other information required by the GPhC Guidance for registered pharmacies providing pharmacy services at a distance including on the internet. People could not choose a prescription-only medicine before starting an online consultation. The website also told people about the pharmacy team and the prescribers the company used. The database was encrypted, and compliance tested quarterly. The pharmacy was cleaned regularly. And the pharmacy team was responsible for keeping it tidy. The pharmacy team had access to appropriate handwashing facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with a range of needs. Its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources and stores them securely at the correct temperature to help make sure they are fit for purpose. The pharmacy team provides people with the information they need to help them use their medicines effectively. The pharmacy team members know what to do when they receive medicine alerts and recalls. And they carry out appropriate checks for affected stock. To make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

People accessed the pharmacy and its services through the pharmacy website. And they could contact the pharmacy via the customer service team by telephone, email or Pharmica chat. The online prescribing service was provided to people who were UK based aged 18 years or over. People needed to complete an online questionnaire or MA when requesting a treatment. People could not add any treatment directly to their basket and were directed straight to the MA. People could not see their score against their answers. If they altered information, such as key responses to questions or weight entries, in order to make themselves eligible for treatment, these changes were automatically recorded without notifying the patient. Pharmacy team members were alerted to the order, and the altered information was investigated during the clinical check to ascertain the reasons behind the changes.

People could not see their score against their answers. And the pharmacy was alerted if a person changed their answers. There were set maximum quantities of medicines which people could not exceed. And products containing duplicate medicines such as cold remedies and Panadol containing paracetamol were flagged. The completed MAs were submitted to and reviewed by one of the prescribers, who if satisfied, approved and generated a prescription, which was sent to the pharmacy electronically. People could be contacted if further information was needed or when they needed to be signposted elsewhere. A pharmacist completed the clinical check. And a clinical check screen was observed during the visit. Team members using the screen could add notes at every stage of the process. And they checked the person's record for any red flags before the medicines were dispensed. The pharmacy' computer system checked for interactions with previous medicines obtained by the person. There was an audit trail showing who checked and dispensed each order. The packaged items were dispatched by couriers with a trackable function and varying delivery options depending on the order and how quickly people wanted it.

People set up an account when they started using the service. There were systems to identify people that had created multiple identities or duplicate accounts at the same address. And identity checks were carried out using a third-party identity checking service. This checked the person's identity and age using electoral roll and credit checks. If the checks failed, or the person was not from the UK, a member of the customer service team would ask them to provide additional proof, such as a copy of their passport or driving licence, to confirm their identity and age. People provided their consent for the service and were asked during the consultation to provide their regular doctor's details and consent for the pharmacy to contact them. This was mandatory before a treatment could be prescribed for asthma.

The pharmacy had processes in place for providing a restricted amount of asthma medicines where people could not supply GP details. And this may be because they were registering with a new GP practice.

The pharmacist could contact the prescriber to discuss the appropriateness of what had been prescribed and they had access to the consultation and the patient's medication history as part of their clinical screening process. The clinical check screen was observed and team members accessing the screen could add notes at every stage of the process. The pharmacy team was able to demonstrate accessing the screen and examples of counselling given to people by email. For example, the pharmacist sent an email with some additional information about safe use when a person had purchased hydrocortisone 1% cream and Eumovate cream at the same time. The clinical screen was only accessible with a pharmacist log on. The pharmacy set maximum treatment periods for certain medicines such as finasteride. Monitoring and follow up for certain treatments was the responsibility of the pharmacist.

At the time of the inspection, the pharmacy was only offering orlistat as a treatment for weight loss. It was not offering GLP-1 medicines pending guidance following the national patient safety alert. People could make changes to their weight record, but the changes were tracked and monitored by the pharmacy team members before a sale could be completed. And they might contact the person for their weight record. For example, with a request for orlistat, the height and weight entered showed the person's BMI to be under 30. The person had ordered inconsistently. So the prescriber was contacted and they refused the sale.

There were examples of orders being cancelled. The patient did not respond to a request for an ID check so the order was cancelled. On the next order, ID was requested and was then sent by the patient. Records of any interactions with customers were routinely made. There was also an interventions log recording when the off-site prescriber had been contacted with a query. For example, with a request for orlistat, the height and weight entered showed the BMI to be under 30. The patient also had ordered inconsistently. So the prescriber was contacted, who refused the sale. Near misses were recorded and patient safety reviews were completed regularly. Each medicine available to purchase on the website had a detailed risk assessment completed with mitigations for each risk identified.

The pharmacy was divided into distinct area for different workstreams so the team members responsible for making up people's prescriptions were in the dispensing area which was fitted out with workbenches. They used baskets to separate items for each person. Items were packed in boxes and a dispensing audit trail was completed. The batch number and expiry date were noted on each item. The dispensary computer screens could be checked for any red flags with a particular order. And if necessary the pharmacy could email the person again. A member of the team explained that most red flags occurred with orders for salbutamol. There were drop sheets for dispatched orders on the pharmacy computer and these were at 'zero' by late afternoon each working day meaning orders had been dispensed and packed in a courier bag. The audit trail also identified the courier bag in which orders were located. This was helpful if an order had to be retrieved before the courier uplifted the orders ready to go. The pharmacy employed the services of different couriers who offered different services over varying timescales depending on what was being dispatched and how urgently it needed to be delivered. The courier collected the prescriptions which were completed, packaged and in a dispatch bag three times a day and when a pharmacist was on the premises.

The pharmacy did not dispense valproates. But members of its team knew about the updated guidance for dispensing and supplying valproates and topiramate. The superintendent and responsible pharmacists conducted clinical audits to monitor the quality of prescribing and other services. The

pharmacy could demonstrate examples of counselling provided via email so people had the information they needed to use their medicines properly. The pharmacy provided a number of examples of orders for salbutamol inhalers which were cancelled for a variety of reasons. For instance, trying to open a duplicate account, not giving any ID, and not having a GP so the pharmacy was unable to confirm the asthma diagnosis.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines neatly on the shelves in their original manufacturer's packaging. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. These things helped reduce the chances of them giving people out-of-date medicines. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. The pharmacy had a process for dealing with the alerts and recalls about medicines issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And it had a process for notifying the MHRA if it had concerns about the medicines it supplied. A team member described the actions they took and what records they made when the pharmacy received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

Inspector's evidence

The pharmacy had access to up-to-date reference sources supporting the services it provided. The pharmacy needed very little equipment for the services it provided. It had medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of each refrigerator on the days the pharmacy was open to make sure the temperature range was suitable. The pharmacy's computers and PMR system were password protected. And access to them and the company's other computer systems was restricted to authorised team members. The website was hosted on an encrypted server / VPN. The database was encrypted and compliance tested quarterly. The pharmacy kept its equipment secure when it wasn't being used. And it disposed of the confidential securely. The company had an in-house information technology support team. Its websites told people that security measures were in place to help protect their personal data.

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.