General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Premier Fillers.Com Ltd/ TA Premier Chemist,

Guardian House, First Floor, Cronehills Linkway, West Bromwich, West Midlands, B70 8GS

Pharmacy reference: 9012089

Type of pharmacy: Internet / distance selling

Date of inspection: 25/09/2023

Pharmacy context

This pharmacy is closed to the public. It is located within an office building near to West Bromwich town centre. The pharmacy does not offer NHS services. It mainly supplies non-surgical cosmetic products on behalf of www.fillerworld.com and occasionally for another third-party website. And the pharmacy also dispenses veterinary prescriptions and supplies pet medicines through www.smartvetmeds.com.

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 generally manages the risks associated with its services. It keeps people's personal information safe and maintains the records it needs to by law. The pharmacy has procedures to make sure the team works safely, and team members are clear about their roles. But it doesn't always fully consider and manage the risks before commencing new services to make sure it operates in the most safe and effective way.

Inspector's evidence

The primary workload in the pharmacy was the supply of non-surgical cosmetic treatments. These were supplied to practitioners for them to administer to people. Most of the items supplied were requested through the website www.fillerworld.com. Both Fillerword and smartvedmeds were closely associated with the owners of the pharmacy.

Prescribers were required to register an account with the Fillerworld website, which allowed them access to the 'ePrescription' function. They provided the details of their professional registration. A photographic identity document, proof of professional indemnity insurance and aesthetic training or competency records were also requested. These details were checked and verified by a pharmacy team member when an account was created. And reconfirmation of professional registration, including a check for any conditions on a practitioner's practice, took place with each separate prescription order that was placed thereafter. An audit trail confirming these checks had been completed was recorded on the practitioner's account profile. An example was seen where a practitioner had requested to register for a prescribing account. During the initial check process, a pharmacy team member had identified that the practitioner did not have prescribing rights. The registration was therefore authorised as a 'customer only' account which meant that they were unable to access the ePrescription portal, but they could purchase other non-prescription items and medical devices, which were fulfilled from a separate location. The prescribers registered with the website were from various healthcare professions, including doctors, dentists, nurses and pharmacists. For each ePrescription generated, prescribing practitioners were required to submit a self-declaration that a physical examination of the person receiving the treatment had been carried out. The date of birth of each person receiving treatment was also supplied, as confirmation that treatments were not being carried out on individuals that were under the age of 18.

A small volume of prescriptions were received from Faces Consent https://facesconsent.com/, which was an independent third party platform. Practitioners using the platform were able to register for an account which provided them with access to the websites ePrescription portal. Pharmacy team members were not involved in the account registration process, but they had access to the 'back-end' of the website, so they were able to check that a review of professional registration had taken place and that additional information such as photographic ID and proof of professional indemnity insurance had been provided. Pharmacy team members also completed their own checks of professional registration, to help ensure that they were satisfied that these independent checks had been completed appropriately. Each prescription generated from Faces Consent required the practitioner to agree to several terms and conditions. As part of this agreement, one of the terms was that the practitioner confirmed that the appropriate clinical and physical assessments had been completed and that they

were following all relevant prescribing guidance. The pharmacy had only recently begun receiving prescriptions from Faces Consent. A pharmacy team member explained that prior to working with the service, members of the pharmacy team including company directors and the pharmacist had informally reviewed the service to consider any risks, but a formal written risk assessment document for this had not been completed. This could mean some risks might not be effectively identified and managed.

The pharmacy had produced several written risk assessments for other aspects of the service, such as prescriber verification through Fillerworld, dispensing prescriptions for Botox, fillers, threads and prescription delivery, including cold chain deliveries. The risk assessments were fairly basic, but they covered the key risks and were stored in a risk management folder.

There were a range of standard operating procedures (SOPs) covering operational activities in the pharmacy. The procedures had been reviewed in February 2023 by a dispenser and the superintendent pharmacist. The procedures had not yet been updated to cover the arrangement with Faces Consent. But a pharmacy team member explained that the superintendent pharmacist was currently reviewing this. Throughout the inspection pharmacy team members appeared knowledgeable about their roles. The pharmacy had up to date insurance arrangements in place. This included professional indemnity but not public liability, but this was rectified after the inspection.

The correct responsible pharmacist (RP) notice was clearly displayed, and the RP log was in order. Records for veterinary prescriptions were recorded in a paper register. Private ePrescriptions were held electronically. A register was maintained as a spreadsheet saved to the computer. This contained the necessary information required of a private prescription register, but it could be amended without an audit trail being maintained. So, any changes to the record may not be clear after the fact. Team members agreed to change the way in which the information was held to a non-editable format. The pharmacy did not supply CDs and had not sourced any unlicensed specials preparations.

There was information on the General Data Protection Regulation and how sensitive information was used and processed on each of the associated websites. The pharmacy was registered in the Information Commissioners Office and a certificate of registration was displayed in the pharmacy. Confidential waste was disposed of using a shredder. The pharmacist confirmed that she had completed safeguarding training in a previous role.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably trained for the jobs that they do, and they manage the workload well. Team members work well together in a supportive environment, where they feel comfortable to provide feedback and raise concerns.

Inspector's evidence

The pharmacy team comprised of the pharmacist and two dispensers, one of whom was a trainee who had only been in post for a short period of time. The pharmacist worked a few days a week at the pharmacy, with another pharmacist covering the remaining days. The pharmacists were usually only present in the pharmacy for a few hours each day. This was sufficient for the current workload in the pharmacy. In the absence of the pharmacist, team members completed administration tasks. Leave was usually planned, and the trainee dispenser was had been employed to enable cover to be provided, as necessary.

A training certificate for the dispenser was displayed at the pharmacy entrance and the trainee had been enrolled on a suitable training programme. The pharmacist, who was intending to increase her hours at the pharmacy in the coming weeks had completed a training course in aesthetics as part of her continuing professional development.

The pharmacy team members worked closely together. The dispenser explained that she escalated any concerns or queries to the pharmacist and provided several examples of there being an open dialogue when making decisions arising from prescription queries. Pharmacy team members could also contact the superintendent pharmacist and company director to escalate any issues.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, and well maintained. It provides a suitable space for the provision of healthcare services. One of the websites associated with the pharmacy does not always provide easily accessible information about how the pharmacy is involved in the supply of prescription medicines. So, it may not always be clear to practitioners using the website who the end supplier of medicines is.

Inspector's evidence

The pharmacy was located inside a large unit in an office block. The unit was in a good state of repair. There were large shelving units used for the storage of medicines, desks for the completion of administration tasks and additional workspace available for dispensing. There was adequate lighting throughout and the ambient temperature was suitably maintained. The pharmacy was secured overnight.

Both the Fillerworld and smart-vet-meds websites displayed the details of the pharmacy, including the registration number, address and details of the superintendent pharmacist. Links were also included to enable website users to check the relevant registration details. Practitioners using the ePrescription function of the Faces Consent website selected the pharmacy they wished to supply their prescriptions. Products were listed as being supplied by Fillerworld, rather than Premier Chemist, and the website contained limited information about the pharmacy. This could be confusing and it may not always be clear to practitioners who is supplying the medication.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible and suitably managed. But prescriptions for aesthetic treatments do not always contain clear instructions for use, so it may not always be possible for team members to identify whether quantities being supplied are suitable for the treatment area. The pharmacy sources and stores its medicines appropriately and it carries out regular checks to help ensure that medicines are kept at the right temperature when they are transported.

Inspector's evidence

People using pharmacy services were able to contact the pharmacy via telephone. The contact number was included on dispensing labels. The details of the pharmacy, including a direct email address were also displayed on the Fillerworld and smart-vet-meds websites associated with the pharmacy.

Prescriptions were dispensed in baskets to keep them separate and reduce the risk of medicines being mixed up. An audit trail for dispensing was maintained on dispensing labels and on order invoices which accompanied prescriptions and were retained in the pharmacy.

Prescriptions were received electronically and were printed before the appropriate stock was selected and dispensed. The most common products were kept in stock and pharmacy team members explained that they contacted practitioners to advise them of any delays to their order. Once dispensed and checked medicines were securely packaged for delivery. Standard items were placed in discreet cardboard boxes labelled with the delivery address. Cold chain items were stored in the fridge and were packaged in polystyrene boxes, with accompanying ice packs, which were assembled and sealed immediately prior to the courier collecting them. These medicines were also labelled to indicate the need for immediate refrigeration upon arrival.

The pharmacist reviewed each prescription and explained that she would query any large volumes of items such as toxins to help ensure that they were being used appropriately. But some requests were labelled as 'use as directed', which made it difficult to confirm that the dose being administered was appropriate. Contact details were held for all prescribers and there had been no previous issues in contacting them when escalating concerns and queries.

Prescriptions for veterinary medicines were ordered online and a copy of the prescription was supplied to the pharmacy. The pharmacy then supplied a self-addressed envelope so that the original prescription could be sent to them. The volume of dispensing for this service was very low.

Prescriptions were delivered by a courier with a specified next day delivery. Delivery was requested by 12 noon for cold chain deliveries. The pharmacy completed a delivery audit with each change in season, where a data logger was used to confirm that the temperature range stayed within acceptable limits during the delivery process. Records of this were retained on the pharmacy for reference. The courier service collected prescriptions once per day and the RP log showed that on occasion, a pharmacist was not present when the collection was made from the pharmacy. So, supplies may not always be being made in accordance with legal requirements. The team agreed to immediately review this moving forward.

Medicines were stored in an organised manner and in the original packaging provided by the manufacturer. A stock audit and date check were completed each month and no expired medicines were identified during random checks. Obsolete medicines were stored in a medicine waste bin. The pharmacy received alerts for the recall of faulty medicines and medical devices. These were currently only received to the dispenser's email. The pharmacy team members agreed to review this to ensure that emails were received to the pharmacy account, which could be accessed by all team members moving forward. An audit trail was kept for relevant alerts.

The pharmacy fridge was fitted with a maximum and minimum thermometer. The temperature was checked and recorded each day and the fridge was within the recommended temperature range. There was also a freezer, which stored ice packs used as part of the delivery process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. And team members use the equipment in a way that protects people’s privacy.

Inspector's evidence

The pharmacy had access to up-to-date resources through unrestricted internet access. Electrical equipment was in working order and there was no risk of information being seen or telephone conversations overheard as public access to the pharmacy was restricted.

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.