General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: E-Surgery and Evaro, Pharmacy Unit, 42 Barnard Road, Bowthorpe Employment Area, Norwich, Norfolk, NR5 9JB

Pharmacy reference: 9012167

Type of pharmacy: Internet / distance selling

Date of inspection: 27/02/2024

Pharmacy context

This pharmacy is located in a business park near Norwich. It is a distance-selling pharmacy which is closed to the public and provides an online prescribing service through its website (e-surgery.com). It offers a range of medications for different conditions such as asthma, weight loss and erectile dysfunction. People wanting to access the prescribing service complete online consultation questionnaires, and these are reviewed by pharmacist independent prescribers (PIPs). The PIPs may then issue a private prescription which the pharmacy dispenses, and the medicines are sent to people by post.

Overall inspection outcome

Standards not all 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 not all met	1.1	Standard not met	The pharmacy does not adequately manage the risks associated with its prescribing service. People can purchase medicines which are high risk or require ongoing monitoring without the knowledge of their regular prescriber or a confirmed diagnosis. And the pharmacy does not adequately assess the risks for all new medicines and conditions added to their website.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	3.1	Good practice	The pharmacy premises are clean, safe, very well maintained and suitably prepared for any future increase in workload.
		3.5	Good practice	The pharmacy provides its services in an environment that is modern, bright and spacious.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy cannot demonstrate that it seeks sufficient information from people requesting higher-risk medicines, including treatment for underactive thyroid, high blood pressure and diabetes to make sure the medicines are clinically appropriate.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately consider and mitigate all the risks of its prescribing service. And there is a risk that vulnerable people might be able to obtain medicines that are not clinically appropriate for them. It has addressed risks regarding the supply of treatments for asthma identified during a previous inspection of the service. But medicines are generally prescribed by relying solely on an online questionnaire. And the pharmacy does not routinely use other resources to verify the information given to it by people to ensure that the treatments it provides are safe and appropriate. The pharmacy does not always obtain consent to communicate with a person's regular practitioner or take additional steps to ensure a medicine is appropriate when prescribing medicines for long-term conditions or higher risk medicines in the absence of consent. So, there is an increased chance of the pharmacy supplying medicines to people when they are not clinically appropriate. However, with regards to other activities, the pharmacy keeps the records it needs to by law. And it manages people's personal information safely and it regularly records and reviews any mistakes so it can learn and improve from these.

Inspector's evidence

The pharmacy's business involved the supply of prescription-only medicines (POMs) to people in the UK via the pharmacy's website. The website had treatments available for a wide range of conditions. And the medicines were supplied against private prescriptions issued by PIPs. The pharmacy did not provide a repeat dispensing service. There was a senior PIP who oversaw the prescribing service.

Anyone signing up to the website had their identity checked using an identity checking service. People then completed the relevant online questionnaire which covered key areas such as medical history and any risk factors that could preclude the person from accessing treatment. Questionnaires were then reviewed by the PIPs who would issue an electronic private prescription if a supply was deemed appropriate. The senior PIP explained how they could contact the person should they need for further information. This would generally be done by telephone or email after the person had submitted the questionnaire, and the PIPs would document their discussions with the person on the internal record. In the majority of records reviewed, the pharmacy was not independently verifying that the person making the request actually had that medical condition or had been prescribed a medicine for it previously. Examples were seen where people had been supplied levothyroxine but there was no evidence to show these people had been diagnosed with an underactive thyroid requiring levothyroxine treatment or had been given levothyroxine by their regular prescriber previously. Another example was seen where a person was supplied ramipril and metformin without evidence they had been prescribed these before. Supplies were also made without any recent blood tests being requested or documented. So, there was risk that people were receiving treatment that may not be clinically appropriate for them. And, in the absence of the person's consent to contact their regular prescriber, a risk-based discussion was not routinely recorded by the PIPs to justify their prescribing decision.

The pharmacy had completed risk assessments which covered the range of conditions that they offered. These included treatments for asthma, under-active thyroid, high blood pressure, hair loss, cystitis, migraine, and weight loss. The risk assessments took into consideration the prescribing activity, this included inclusion and exclusion criteria and age restrictions. The risk assessments also took into consideration when the person should be referred to the GP depending on if there were any concerns

raised from the questionnaire or conversation with the person. The system could also see if a person changed their answer, and this was flagged to the prescriber when reviewing the questionnaire. This included altering height and weight when requesting weight loss medicines. An example was seen where a request for bendroflumethazide was rejected due to change in answers and no proof of prescription. Extra checks were put in place to ensure medicines were not over ordered. The checks included reviewing the number of times the person had ordered a treatment and when they had last ordered a treatment to prevent over supply. The pharmacy also had limits on the quantity it would supply at any one time.

The pharmacy indicated on its website that it could supply orlistat, Wegovy and Mounjaro for weight loss. The pharmacy asked people for their BMI and were able to see if a person changed their answers in order to achieve a BMI which would qualify for weight loss treatment. The pharmacy also required people to provide their GP details in order to complete the consultation.

The pharmacy had completed a number of audits to review its prescribing to see if risk assessments were being followed. Examples were seen of audits reviewing the prescribing of medicines for urinary tract infection (UTI) and chronic obstructive pulmonary disease (COPD). The outcomes of these audits showed that processes were being followed, and consultations and medicine supplies were being completed appropriately, with orders being rejected when requested inappropriately.

The responsible pharmacist (RP) during the inspection was also the superintendent pharmacist (SI). The pharmacy had standard operating procedures (SOPs) available electronically. The SOPs had been read by all team members and they had signed to say that they had read them. The SOPs had been reviewed in 2023 . All team members including the SI had completed level two safeguarding training, and the pharmacy had details of local safeguarding contacts.

In relation to dispensing activities, the pharmacy recorded near misses (mistakes spotted before a medicine reached a person) on a paper log sheet in the dispensary. The SI said that the team had monthly meetings to discuss the errors and look for any trends that occurred. Dispensing errors (mistakes that had reached a person) were recorded on a separate log in more detail. A root cause analysis was done for each error to find out how it occurred and how it could be prevented from occurring again and the outcome recorded on the person’s medication record (PMR).

The pharmacy had a complaints procedure. People could make a complaint about the pharmacy or provide feedback by completing a form on the pharmacy's website which would be viewed and actioned by the customer services team. From here, complaints could be forwarded to the SI if necessary for pharmacy intervention and review. As well as this, reviews could also be left on the website Trustpilot. The vast majority of the reviews seen were positive.

The pharmacy had up-to-date professional indemnity insurance. All PIPs were required to have individual indemnity cover. The correct RP notice was displayed in the dispensary. The pharmacy kept records of its prescriptions on its electronic private prescription register. This was largely maintained in line with legal requirements, although some records did not have the correct address of the prescriber. The SI said that going forward, this would be checked more thoroughly. The pharmacy did not store or supply any controlled drugs (CDs) or items requiring refrigeration. The pharmacy did not order any unlicensed medicines and did not make emergency supplies of medicines to people. The RP log was completed with all entries seen having a start and finish time. The pharmacy handled confidential waste appropriately. Confidential waste was shredded as soon as it was no longer needed. And the pharmacy had a privacy policy on its website detailing how they would use people’s personal information.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload effectively. Its team members do the right training for their roles and the services they provide. And they do ongoing learning to keep their knowledge and skills up to date. They have a regular formal review of their progress. And team members can raise any concerns that they have.

Inspector's evidence

The pharmacy had six full-time dispensing staff, a regular pharmacist and one other pharmacist who worked part-time in the pharmacy. It also had five PIPs who worked remotely for the pharmacy. The PIPs were remunerated on an hourly basis and not per prescription they issued which reduced the risk of any prescribing for financial gain. Dispensary staff had completed the required training for their roles. They were also given protected time for further training and learning and had informal meetings monthly to discuss their progress. And a regular formal review took place quarterly with each team member to discuss their progress. Team members were able to raise any issues that they had. This could be done at meetings or raised directly to the SI or owner. Team members were not set any targets.

PIPs completed an onboarding process at the end of which they needed to sign a self-declaration to confirm they understood the SOPs and risk assessments. They also had to declare they had self-assessed themselves as competent to prescribe in the various therapeutic areas. Evidence of the self-declaration forms for all PIPs was provided shortly after the inspection along with CVs showing that the PIPs had completed the necessary prescribing qualifications for their role. PIPs were signposted to training resources. There was evidence seen of continued learning and assessments that prescribers had completed to help keep their knowledge and skills up to date. PIPs were given a month's notice before a new medicine was made available to be prescribed and they had to complete the necessary training and declare themselves competent to prescribe the medicine. And if there were any learning needs, the pharmacy had access to various external clinicians such as doctors who were experts in different clinical areas.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s website gives people information about the pharmacy and the prescribers it uses. So, people can check who prescribes their medicines. The premises are very clean and tidy and have more than enough space for team members to safely carry out their work, and the pharmacy is kept secure from unauthorised access.

Inspector's evidence

The pharmacy's website which people used to access the prescribing service displayed the GPhC voluntary logo. The website also displayed the name of the prescribers, the SI, and team members. It also gave the address of where medicines were supplied from. On the website, people selected the treatment area they required; people could not start a consultation from the page of a specific medicine. Medicines were listed under a main page for each condition. People could click on a medicine and would be taken to another page which displayed more information about the medicine. From this page, a consultation could be started.

The dispensary was very clean and tidy. And it had plenty of space for team members to work in. The SI said there was extra space in the dispensary to account for any future increase in workload. The lighting and temperature of the pharmacy were appropriate, and the pharmacy had central heating and air conditioning which could be used to adjust the temperature as necessary. The pharmacy had toilets available for team members, these were clean and had access to hand wash and hot and cold running water. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always provide all its services safely. It prescribes a range of medicines including higher-risk medicines and medicines for conditions which require ongoing monitoring. And in the majority of cases, it cannot demonstrate that it seeks sufficient assurances from people requesting these medicines to make sure they are only supplied when clinically appropriate. This increases the risk of the pharmacy supplying medicines to people when they are not clinically appropriate. However, the pharmacy gets its medicines from reputable suppliers and stores them properly.

Inspector's evidence

The pharmacy's services were accessed via the E-Surgery website and consultations were largely via an online questionnaire. In some cases, contact could take place over phone call or email between the person and the pharmacy after the questionnaire had been completed to discuss any further queries. Evidence was seen of some emails between PIPs and people to request further information such as previous prescriptions to help make a prescribing decision, although this did not routinely occur. The majority of the prescribing reviewed was for asthma, UTIs and a range of medicines for chronic conditions.

Medicines were only supplied to people living in the United Kingdom. People were required to create an account after completing the online consultation questionnaire in order to complete their purchase. The pharmacy was closed to the public with all medicines being delivered to people. But people could contact the pharmacy by email or by phone and contact details were available on the pharmacy's website. The customer services team was the first point of contact and would refer to the SI if needed. ID checks were carried out at the point of ordering. Once registered, there was an ID verification check undertaken to make sure the person was who they said they were, and the system flagged up people who could not be verified. In these cases, the pharmacy sought further clarification and assurance that the person was who they had said they were. The pharmacy had introduced a checking system to help flag multiple accounts. This involved a manual check using the pharmacy software to ensure people requesting did not get repeated supplies. The pharmacy had very recently been granted access to NHS summary care records (SCR). One of the PIPs verbally explained that they had recently started to access people's records and some examples were seen of records being made by PIPs when SCR was accessed.

The information captured in the questionnaires covered the main key points to help inform a PIP's prescribing decisions. Completed questionnaires were reviewed by a PIP before a decision could be made if the person was suitable for the treatment. If the person qualified for the treatment, the PIP would sometimes contact people via the telephone or email. The senior PIP explained that, when the person was contacted, she documented the full consultation on the internal record and evidence was also seen of the other PIPs doing the same. The PIPs had the autonomy to decide if they issued a prescription and if they were unsure, they would not prescribe. An example of this was seen for a person who requested bendroflumethazide and the prescriber deemed it unsafe to prescribe and signposted the person to their GP.

In most cases, the pharmacy relied on people's answers to online questionnaires before prescribing a medicine. And it did not always independently verify people's medical history when prescribing higher-risk medicines such as levothyroxine or blood pressure medication. The pharmacy did not

independently verify that people with conditions such as high blood pressure, underactive thyroid and diabetes were being monitored or check that the person had a suitable diagnosis in the majority of the cases.

Following action from a previous inspection, the pharmacy no longer supplied propranolol for treatment of situational anxiety. The pharmacy also now asked for mandatory consent to inform people's regular prescriber when prescribing treatments for asthma and COPD treatment. The senior PIP explained that evidence of supply of asthma medicines was emailed to the person's surgery and evidence of this was seen. However, most patients did not provide their consent for the pharmacy to inform their regular prescriber about all other areas of prescribing including some medicines which required ongoing monitoring or were high risk.

Prescribers used evidence-based guidelines and local formularies to help inform prescribing decisions for all conditions. And evidence was seen of orders being put on hold when a supply had been deemed inappropriate. Antibiotics were prescribed and dispensed for UTIs and some sexually transmitted infections (STIs). The pharmacy had a restriction where only one course was supplied every 12 weeks and on the third supply a referral was made to the GP.

The pharmacy could cater for people with accessibility issues such as being able to print large print labels for people with sight impairment. The pharmacy had separate areas for dispensing and checking medication. Prescriptions generated by the PIPs were clinically checked by the RP. Medicine labels were signed by both the dispenser and checker to help keep an audit trail. The pharmacy obtained its medicines from licensed wholesalers. Medicines were stored on shelves in the dispensary and the shelves were neat and tidy. A random check of medicines on the shelves found no expired medicines. Expiry date checks were carried out every three months on a rota basis. The pharmacy had some pre-packed labelled stock. This was labelled with the batch number and expiry date of the medication.

The pharmacy delivered all its dispensed medicines to people. This was done through a 3rd party courier service. All deliveries were tracked, and the person ordering provided with a tracking number. Deliveries could be made by a 24 or 48 hour tracked service or by next day special delivery. If a delivery could not be made it was returned to the pharmacy for safe disposal. No CDs or items requiring refrigeration were posted. The pharmacy did not stock sodium valproate. Safety alerts of medicines and medical devices were received by email. These were printed before being actioned as appropriate and then archived in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. And it uses this equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had access to the internet which allowed team members to access any online resources that they needed. The computers were all password protected. And each team member had a separate login with two factor authentication to increase security. The pharmacy had headsets which could be used when taking calls over the phone so that conversations could be had in private if necessary. The electrical equipment was overdue to be safety tested; the SI said that this would be completed. The dispensary had fire extinguishers which had been checked recently.

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.