General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Oxford Online Pharmacy, Unit 1B, Apollo Office Park, Ironstone Lane, Wroxton, Banbury, Oxfordshire, OX15 6AY

**Pharmacy reference:** 9012205

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 14/08/2024

## Pharmacy context

This is an internet pharmacy in a business park outside Banbury. It dispenses NHS and private prescriptions and it offers services through its website https://www.oxfordonlinepharmacy.co.uk/ . 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 doctors. The pharmacy mainly supplies medicines to people living in the United Kingdom (UK) and aged 18 years of age and over. It dispenses medicines on veterinary prescriptions under the cascade.

## 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 met | 1.1 | Good practice | The pharmacy has written risk assessments (RAs) for all its services and the medicines it provides to manage the risk associated with providing online pharmacy services. |
| | | 1.2 | Good practice | The pharmacy regularly audits treatment areas and how medicines are prescribed to monitor the safety and quality of its services |
| **2. Staff** | Standards met | 2.2 | Good practice | The pharmacy team members are encouraged and supported to complete training to keep their skills and knowledge up to date. And share learnings from audits to support them providing safe services. |
| **3. Premises** | Standards not all met | 3.1 | Standard not met | The website promotes a small number of products to be used outside the scope of their product licences. |
| **4. Services, including medicines management** | Standards met | 4.2 | Good practice | Pharmacy team members get all the information they need from people to be sure the medicines they supply are safe and appropriate. And they support people with the information they need to help them use their medicines effectively. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy is good at identifying and managing the risks involved in providing its services. It has suitable written instructions to help its team members to work safely and effectively. It continually audits its online services to effectively monitor and improve 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 members 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 provided by doctors and regulated by the Care Quality Commission (CQC). The website offered treatments for a comprehensive range of conditions such as hair loss, erectile dysfunction, eczema, cold sores and migraines. The prescribers were United Kingdom (UK) based and worked remotely. The pharmacy only provided its services to people living in the UK. The pharmacy risk assessed each pharmacy process and treatment category and produced written risk assessments and policies for the services it provided. It maintained a company risk register.

The pharmacy reviewed the risks associated with the types of medicines it supplied. And it had produced a best practice guide for prescribing for treatments for some popular conditions. It had not supplied 'off-label' weight-loss medicines irrespective of the National Patient Safety Alert. The pharmacy did not prescribe painkillers containing controlled drugs (CDs) or opiates but if appropriate, a short course of non-steroidal anti-inflammatory drugs (NSAIDs) such as naproxen, indomethacin or ibuprofen was prescribed. And in certain circumstances, for instance the age of the person, the prescriber added a proton pump inhibitor (PPI) such as lansoprazole to protect the stomach.

The pharmacy had made a decision not to prescribe high-risk medicines such as anti-depressants or propranolol. The prescribers sometimes prescribed medicines such as oral minoxidil which was 'off-label' or unlicensed for hair loss and this was explained to the person receiving the supply of off-label medicine. The pharmacy's risk assessment (RA) for skin conditions required people to produce recent photographs of the affected area. The RA recommended that the only steroid preparation prescribed was betamethasone for Psoriasis and its use was monitored and limited to one tube at a time. The pharmacy team did not initiate hormone replacement therapy (HRT) but they would dispense it as a repeat treatment. And not if it contained two types of oestrogen and no progesterone.

The pharmacy kept a record of decisions to refuse to supply a medicine. The superintendent pharmacist (SI) described an intervention where a person had completed a consultation questionnaire for a specific condition but they were outside the age limit recommended for treatment in the RA so the prescriber contacted the person and signposted them elsewhere to seek treatment. The prescriber recorded interventions on the patient notes so they were always visible during consultations. For a person who has had an eating disorder, the pharmacy did not block the account in case the person just tried to open a new account. The prescriber alerted the person and recorded a clinical intervention. The background of the person's account was red to flag up the alert to pharmacy staff even if the prescriber

approved future supplies of a medicine.

The pharmacy had produced different consultation questionnaires for each condition, so the questions were tailored to a particular condition. The person could click on a prescription only medicine (POM) on the website, read information and prices before completing the consultation questionnaire. If approved, a medicine could be added to their basket. The pharmacy required people to complete a consultation and give the pharmacy consent each time they wanted to order medicine. The prescribing doctor could see order history and all previous answers given by the person seeking treatment including their height and weight. In line with the risk assessment (RA) for weight loss, the prescriber verified a person's medical information via a video call, checking their body mass index (BMI), national care record (NCR) and writing to the person's GP. People could provide feedback via Trustpilot and by email. Following a treatment the person received an email from Customer service to which they could reply with feedback.

The pharmacy conducted an automated identity check via Fast Identity Online (FIDO) background identity check for new people registering online for the first time. It asked people for their date of birth, NHS number, passport and driving licence. If the person was picking a Pharmacy only 'P' medicine, the completed consultation form was clinically checked by a pharmacist. For instance, people wanting to purchase over-the-counter orlistat would complete the consultation form and include certain information but the pharmacist assessing the information would check the body mass index (BMI) value and order history before approving. The pharmacist completing the clinical checks for purchases of NSAIDs would check the age of the purchaser, other medicines they take for other medical conditions and the NCR if they are over a given age to establish the need for a PPI. When consultation notes were sent to the doctor, alerts were visible but the order notes section was not visible.

The pharmacy monitored the use of medicines and the SI described monitoring a weight loss medicine by maintaining a spreadsheet to detect misuse which in the case of weight loss medicines may have been due to an eating disorder. The pharmacy conducted monthly prescribing audits for each doctor on a rotation of treatments and collated feedback was reviewed by the clinical lead person. The audit plan specified the prescribed medicine to be audited each time.

The pharmacy had processes to deal with the dispensing mistakes that were identified before the items had left the pharmacy. Pharmacy team members discussed, reviewed and recorded the mistakes they made to learn from them, and help stop the same mistakes happening again. The team had identified a recurring near miss which was not obviously due to similar packaging or name but both packs contained the same number of tablets. The log of near misses was reviewed weekly with the team and minutes of the discussion minutes recorded. The pharmacy also maintained a spreadsheet of incidents such as interactions between medicines taken by the same person. Or unusual weight loss results reported by people on their consultation questionnaires. The spreadsheet was circulated to the doctors and pharmacists for discussion at the monthly clinical meeting which was recorded in the minutes.

Prescriptions being dispensed had a tracking number on the reverse and an electronic signature. The pharmacy used baskets to separate medicines and prescriptions. Labels were generally automated. The dispensary benches were divided into sections to assist workflow and team members were rotated around different sections of the dispensary. This ensured members of the team could maintain their skills and interchange roles. And prescriptions and medicines were clinically and final checked by the pharmacist at the end of the process before being packed for dispatch with the courier. The pharmacy team maintained audit trails so every team member involved in preparing prescriptions could be identified from the start of the process. There were different categories of delivery depending on what the medicine was so for instance cold chain items required a quick delivery time in packaging which helped maintain the goods between two and eight Celsius. The couriers provided a tracked service.

The pharmacy had insurance in place, including professional indemnity, for the services it provided. There was a set of recently reviewed standard operating procedures (SOPs) for every part of the pharmacy operation including P medicines and pre-authorisation process. The pharmacy's customer service team sent an email to follow up on treatment. The pharmacists highlighted customer feedback to the team members. The pharmacy displayed a notice that identified who the responsible pharmacist (RP) was and the RP record was completed. It did not supply CDs or special unlicensed medicines and private prescriptions were recorded in an electronic register.

The pharmacy was registered with the Information Commissioner's Office (ICO). Its website explained to people how their personal information was gathered, used and shared by the pharmacy and its team. And the pharmacy had arrangements to make sure confidential information was stored and disposed of securely. Members of the pharmacy team had read and signed a confidentiality agreement. The superintendent pharmacist (SI) had trained to level 3 in safeguarding. The remaining team members had trained to level 2 and they were up to date. They knew what to do or who they would make aware if they had a concern about a vulnerable person. The SI was signposted to the NHS safeguarding App.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy’s team members work well together to manage their workload and deliver services with safe and effective care. They are suitably qualified or in training to have the appropriate skills for their roles. And the pharmacy is good at supporting them with their ongoing training to keep their knowledge and skills 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 consisted of the SI, the owner and a further five pharmacists, five dispensers, five medicines counter assistants in the role of customer service team and three packers. Team members were enrolled on or had completed accredited training in line with their roles. And they could study in protected learning if needed. The pharmacy maintained training records for each member of the team. The prescribing service was provided by five doctors registered with the General Medical Council (GMC) and regulated and inspected by the Care Quality Commission (CQC). The pharmacy team monitored the capacity of the business and planned staffing levels and suitability of the premises. It had a locum guide to support locum members of the team.

The pharmacy accessed ongoing training for team members via a healthcare training provider. The pharmacy provided members of the team with training such as blood tests for cholesterol and about Mounjaro. The SI produced printed examples of team training completed on a new product in November 2023. The training session was minuted and included attendees, how it was to be prescribed, treatment period, user information and yellow card reporting.

Mandatory training was provided on health and safety, safeguarding, fire safety and General Data Protection Regulation (GDPR). An example of a clinical governance meeting was also minuted, showing attendees, and the SI had highlighted clinical update and review of the previous meeting action points, near miss and complaints/incidents. And follow up to findings from a prescribing audit.

Pharmacy team members attended a weekly meeting which was minuted, and displayed and available in the team file. New products, near miss records were discussed and learnings were shared to improve services and patient safety. They could make suggestions about how they could improve services during ‘Any Other Business’ at the end of the meeting. And one team member described providing feedback on an improved way of checking totes with the handheld device.

The monthly clinical meeting was attended by the clinical lead person, doctors and pharmacists to discuss prescribing reviews, incidents such as significant weight loss reported by a person requesting weight loss medicines. And the results of regular clinical audits to ensure safe prescribing and pharmacy services. Each team member had regular one-to-one meetings with their line manager and a six-monthly appraisal to talk about what they had achieved and what they would like to achieve in the next six months.

## Principle 3 - Premises **Standards not all met**

### Summary findings

Overall the website displays relevant information to meet GPhC guidance for registered pharmacies providing services at a distance, including on the internet. But it also promotes a small number of products to be used outside the scope of their product licences. The pharmacy is clean, bright and secure and it provides a suitable environment to deliver its services. The premises are suitably equipped to protect the pharmacy's medicines stock and people's private information when the business is closed.

### Inspector's evidence

The registered pharmacy premises were set in a two-storey office unit in a business park. The dispensary was on one floor and the administration including customer services and staff facilities were on the other floor. The premises were air-conditioned, well-lit including natural light and clean. And were only accessible to authorised people. The pharmacy benches were tidy and clean. And cleaning records were maintained.

The website associated with the pharmacy mostly provided the information in line with GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. People could read about individual medicines but had to complete the online consultation to obtain any. The website did promote a small number of products available on prescription, to be used to treat conditions which were not within the scope of their product licences. This means these medicines had not been assessed for how safe and effective they were when used to treat conditions which were not stated in their licence. The website included information about all the prescribers and the clinical team, the address and details of the SI and how to complain. The privacy policy set out how personal information was gathered, used and shared by it and its team.

## Principle 4 - Services ✔ Standards met

### Summary findings

Members of the team get all the information they need from people so they can check the medicines they supply are appropriate. They are good at using this information to support people and help them use their medicines effectively. The pharmacy and its services are easily accessible to people with different needs. Its working practices are safe and effective. The pharmacy obtains its medicines from reputable sources and stores them securely at the correct temperature to help ensure they are fit for purpose. The pharmacy delivers all its medicines, and it has systems in place to show it has delivered them to the right people. 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's website which listed several ways to contact the pharmacy and displayed its opening hours under 'Contact us' at the top of the website. People could access the website 24 hours a day and the customer services team every day during working hours. There was information explaining that this was not an emergency service and who to contact for an emergency and in less urgent situations.

The online prescribing service was provided to people aged 18 or over. The prescribers worked in line with prescribing SOPs and policies which followed local and national best practice guidance when prescribing treatments. People needed to complete an online questionnaire when requesting a treatment. The responses submitted were reviewed by one of the prescribers, who if satisfied, then approved and generated a prescription, which was sent to the pharmacy electronically. But a patient could be contacted for further information or to be signposted to another clinician or provider. The pharmacy had updated its business continuity plan so it could continue to provide services following an adverse event. If needed it has additional workspace and people can work from home.
It monitored its business capacity to plan future suitability of premises and recruiting people to the various teams with changing business needs. For instance, it had its own information technology (IT) department to support its website and online systems.

The pharmacy team could understand or speak languages such as Romanian, Arabic or Hindi to assist people whose first language was not English. People were given counselling advice on using each treatment and this was printed on their receipt and provided via 'patient guides' which the pharmacy produced and supplied with dispensed medicines. For instance, the hair loss treatment patient's guide descibed the purpose of the leaflet, the condition, side effects of treatment, questions and answers about the medicine and a QR code to read further information. People also agreed to read the patient information leaflet (PIL) with their medicine when they completed the consultation questionnaire. Although not supplied at this pharmacy the pharmacy team members were aware of new rules for supplying sodium valproate in original containers with appropriate warnings visible. And this had been extended to supplying topiramate.

Prescriptions being dispensed had a tracking number on the reverse and an electronic signature. The pharmacy used baskets to separate medicines and prescriptions. Address and dispensing labels were

generally automated. The dispensary benches were divided into sections to assist workflow and team members were rotated around different sections of the dispensary. This ensured members of the team could maintain their skills and interchange roles. And prescriptions and medicines were clinically and final checked by the pharmacist at the end of the process before being packed for dispatch with the courier.

The pharmacy team maintained audit trails so every team member involved in preparing prescriptions could be identified from the start of the process. There were different categories of delivery depending on what the medicine was so for instance cold chain items required a quick delivery time in packaging which helped maintain the goods between two and eight Celsius. The couriers provided a tracked service and assembled prescriptions were dispatched from the pharmacy premises under the supervision of the RP. There was a process for failed deliveries. The pharmacy team recycled as much waste packaging as possible.

People were required to set up an account when they started using the service. There were systems to identify people that had created multiple identities or accounts and these checks were made on a monthly basis. Identity checks were carried out using a third-party identity checking service. 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 details. Each tailored consultation form provided included a section at the end asking for the person's surgery details and explaining why they were required along with people's consent to treatment, identity check and access to the national care record.

The pharmacists who checked prescription items could contact the prescribers to discuss what had been prescribed. They also had access to the consultation and the patient's medication history as part of their clinical screening process. People who were prescribed weight loss medicines such as Mounjaro were supported further by clinicians who specialised in nutrition and exercise. They provided weight readings at intervals and if there was a significant discrepancy in weight loss, they were followed up with a video call. The SI described examples of clinical interventions where they prevented the inappropriate supplies of medicines including a UTI treatment for an elderly patient. And the patient medication record (PMR) system was routinely used to record the clinical interventions made by the pharmacy team. The pharmacy dispensed veterinary prescriptions and produced a sample of prescriptions during the inspection prescribed by a veterinary surgeon for administration under the Cascade. The pharmacy had supplied a UK medicine licensed for human use as there was no licensed veterinary medicine.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And medicines were stored neatly on the shelves in their original manufacturer's packaging. Members of the pharmacy team checked the expiry dates of medicines regularly. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature and the fridges were monitored constantly. It collected its waste medicines in pharmaceutical waste bins which were removed for at an agreed interval for safe disposal. 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. The responsible pharmacist 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 the facilities it needs to provide its services safely. And its team makes sure the equipment protects private information.

### Inspector's evidence

The pharmacy had access to up-to-date reference sources. And these were relevant to the services it provided. The pharmacy needed very little equipment for the services it provided. It had several medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly monitored and recorded the maximum and minimum temperatures 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. And the confidential waste it produced was stored and disposed of securely. The pharmacy had its own IT department and information was protected by an encryption programme.

## 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. |