Red Label Medical Limited

The Independent Pharmacy

Inspection report

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Overall summary

Letter from the Chief Inspector of General Practice

The Independent Pharmacy is an online service providing patients with prescriptions for medicines that they can obtain from the provider's registered pharmacy.

We carried out an announced focussed responsive inspection at The Independent Pharmacy on 17 October 2017. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions and in response to concerns we received about the provider's prescribing practices from another regulatory body. The inspection was to check whether the service was undertaking safe prescribing and that the governance arrangements ensured systems and processes were operating effectively to ensure patient safety. Therefore, this inspection focused on the safe and well-led key questions.

We had previously carried out an announced comprehensive inspection on the 25 April 2017 where we found that the provider did not provide safe, effective and well-led services in accordance with the relevant regulations. We did however find that the provider delivered caring and responsive services in accordance with the relevant regulations.

At this inspection on the 17 October 2017, we found the provider was working through a plan in relation to the actions we had told them they needed to take and had made a number of improvements. We found that in some areas this service was not providing safe, effective and well-led services in accordance with the relevant regulations. As such our judgement from our previous inspection on the 25 April 2017, that this service was not providing safe, effective and well-led services in accordance with the relevant regulations remains unchanged.

Specifically, we found:

- Patients were prescribed a range of medicines following consultation with a clinician. There were systems in place to ensure that excessive amounts of medicines were not supplied and the provider had improved its system to ensure prescriptions were not issued if the service had any concerns for the safety of the patients.
- Systems to mitigate safety risks including analysing and learning from significant events and safeguarding were being developed.
- The provider was undertaking a risk assessment for the areas of prescribing where they would need to share information about treatment with the patient's own GP in line with General Medical Council guidance.

Summary of findings

- Some medicines used to treat long term conditions, such as for high blood pressure, had been suspended until a safe system was implemented to ensure patients received the appropriate monitoring from their own GP.

The areas where the provider should make improvements are:

- Continue to develop and improve the management of significant events, incidents and alerts to ensure leaning points are identified and cascaded to all staff.
- Continue to risk assess the areas of prescribing to ensure patients' own GPs are consistently informed of treatment where appropriate.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our judgement from our previous inspection on the 25 April 2017, that this service was not providing safe care in accordance with the relevant regulations remains unchanged. The provider was currently working through their action plan on the actions we told them they needed to take to provide safe, effective and well-led services. We found that in some areas this service was not providing safe services in accordance with the relevant regulations. However, they had made a number of improvements.

At this inspection we found the following in relation to the reported concerns:

- Patients were prescribed a range of medicines following consultation with a clinician. There were systems in place to ensure that excessive amounts of medicines were not supplied and the provider had improved its system to ensure prescriptions were not issued if the service had any concerns for the safety of the patients.
- Systems to mitigate safety risks including analysing and learning from significant events and safeguarding were being developed and improved.
- The provider was undertaking a risk assessment for the areas of prescribing where they would need to share information about treatment with the patient's own GP in line with General Medical Council guidance.
- The prescribing of some medicines used to treat long term conditions, such as for high blood pressure, had been suspended until a safe system was implemented to ensure patients received the appropriate monitoring from their own GP.

Are services well-led?

Our judgement from our previous inspection on the 25 April 2017, that this service was not providing well-led services in accordance with the relevant regulations remains unchanged. The provider was currently working through their action plan on the actions we told them they needed to take to provide safe, effective and well-led services. We found that in some areas this service was not providing well-led in accordance with the relevant regulations. However, they had made a number of improvements.

At this inspection we found the following in relation the reported concerns:

- There was an overarching governance framework to support clinical governance and risk management.
- Risk assessment for the areas of prescribing where the provider may need to share information about treatment with the patient's own GP were being developed.
- We saw evidence of monthly clinical meetings taking place where prescribing and medicines were discussed.
- There were systems in place to ensure approved consultation and prescriptions were monitored and that these were appropriate.

The Independent Pharmacy

Detailed findings

Background to this inspection

Background

The Independent Pharmacy is the trading name of two companies, ABSMHealthcare Ltd and Red Label Medical Ltd. ABSM Healthcare Ltd operates the organisation's affiliated pharmacy (which does not require registration with the Care Quality Commission) and Red Label Medical Ltd operates the online consultation service. We inspected the online consultation service only, which is located at the following address:

Unit 3, Heston House, Emery Road, Bristol, BS4 5PF.

The Independent Pharmacy was established in 2013, and provides an online service that allows patients to request prescriptions through a website which are then directed to the pharmacy business which is part of the same legal entity. Patients are able to register with the website, select a condition they would like treatment for and complete a consultation form which is then reviewed by a clinician and a prescription is issued if appropriate. Once the consultation form has been reviewed and approved, a private prescription for the appropriate medicine is issued. This is checked by a pharmacist at the affiliated pharmacy (which we do not regulate) before being dispensed, packed and sent to the patient by secure post.

The service can be accessed through their website, www.the independentpharmacy.co.uk where patients can place orders for medicines seven days a week. The service is available for patients living in the UK only. Patients can access the service by phone or e-mail from 9am to 5pm, Monday to Friday. This is not an emergency service. Subscribers to the service pay for their medicines when making their on-line application.

The provider employs staff who work on site including dispensing staff and pharmacy technicians. They also employed clinicians who worked remotely including two GPs, one doctor (who was not a GP) and one prescribing pharmacist.

Red Label Limited was registered with Care Quality Commission (CQC) on 14 January 2014 and have a registered manager in place. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

How we inspected this service

Our inspection team was led by a CQC Lead Inspector accompanied by a GP Specialist Advisor.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew.

During our visits we:

- Spoke with a range of staff including two Directors and a GP.
- Reviewed a sample of patient records.

We carried out an announced focussed responsive inspection following concerns we received from another regulatory body.

This was a focussed responsive inspection, which focussed on the following two key questions:

- Is the service safe?
- Is the service well-led?

Detailed findings

These questions therefore formed the framework for the areas we looked at during the inspection.

Why we inspected this service

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions and respond to concerns we received about prescribing from another regulatory body. This inspection was planned to check whether the service was undertaking safe prescribing and that the governance arrangements ensured systems and processes operated effectively to ensure patient safety.

Are services safe?

Our findings

We found that in some areas this service was not providing safe services in accordance with the relevant regulations. However, they had made a number of improvements.

Prescribing safety

All medicines prescribed to patients from online consultation forms were monitored by the provider to ensure prescribing was evidence based. If a medicine was deemed necessary following a consultation, the clinicians were able to issue a private prescription to patients. The clinicians could only prescribe from a set list of medicines which were advertised on their website. There was a system in place to prevent the misuse of medicines. For example, the provider compiled a list of patients to whom they would not supply due to risks of medicines being misused based on past orders. Orders being received were crossed referenced with this list to ensure patients who tried to use multiple identities were picked up.

When consultation forms were sent to clinicians for review, it included clinical guidance on the medicines or conditions for which the patient had requested medicines for. The clinical guidance gave clinicians clear information on the circumstances where it would be appropriate to prescribe.

The provider issued prescriptions for long term conditions, based on information supplied by the patient which demonstrated that they had previously been prescribed the medicine. These prescriptions included medicines for conditions which require regular monitoring. Systems had been put in place to ensure that patients only received a limited amount of those medicines to encourage them to attend the required reviews with their own GP. For example, patients could only order two specific asthma inhalers within a two months period. If patients placed another order for these medicines within the two month period, the order was declined and patients were referred to their own GP. Although patients were required to provide the details of their own GP to obtain a prescription for asthma inhalers, the provider had a policy to supply one inhaler in urgent circumstances even if the details of their GP had not been provided. We were told that future orders would be declined in line with the provider's clinical guidance and we saw evidence that this had been adhered to. These actions had been implemented since our previous inspection.

Medicines for the management of high blood pressure had been suspended since April 2017, as the provider had concerns about the monitoring of patient's blood pressure. The provider told us that this action was necessary to ensure patients had received appropriate monitoring. However, we reviewed three records relating to patients who had requested medicines for high blood pressure before April 2017 and found that patient's own GP was informed of the treatment. One patient's medicine request was declined due to not supplying the details of their own GP so that they could be informed of the treatment.

The provider supplied medicines for the management of situational anxiety (symptoms of anxiety experienced by patients in specific circumstances). We reviewed two records relating to these medicines, one of which related to concerns raised with us by another regulatory body. The provider had investigated those concerns and identified improvements which they had implemented within their consultation forms in order to capture further details about the patient's condition. We saw from the other record we reviewed, that the consultation was appropriate and decisions were made in line with the provider's clinical guidance.

Management and learning from safety incidents and alerts

Systems for identifying, investigating and learning from incidents relating to the safety of patients and staff members were being improved and developed. The provider held monthly clinical meetings and we saw from minutes of these meetings that incidents were discussed and actions to prevent the same thing happening were implemented and shared with all staff. However, although actions were identified and implemented, the provider did not always identify these as learning points.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We found that in some areas this service was not providing well-led in accordance with the relevant regulations. However, they had made a number of improvements.

Business Strategy and Governance arrangements.

There was an overarching governance framework to support clinical governance and risk management. There were a variety of checks in place to monitor the performance of the service. These included random spot checks for consultations. The information from these checks was used to produce a clinical team report that was discussed at monthly team meetings. We saw evidence from minutes of those meetings that medicines and prescribing practices were discussed. This ensured a comprehensive understanding of the performance of the service was maintained.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Risk assessment for the areas of prescribing where the provider would need to share information about treatment with the patient's own GP were being developed. There were systems in place to ensure approved consultation and prescriptions were monitored and that these were appropriate.