General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Healthxchange Pharmacy UK Limited, 79 Great Portland Street, LONDON, W1W 7LS

Pharmacy reference: 1097264

Type of pharmacy: Community

Date of inspection: 07/03/2024

Pharmacy context

This pharmacy is located central London. The pharmacy specialises in supplying aesthetics and skincare products. It primarily dispenses private aesthetic prescriptions for people living the UK. The aesthetic service is accessed via the pharmacy's website www.healthxchange.com. The pharmacy sells a small range of over-the-counter medicines and dispenses a very small number of NHS prescriptions. The pharmacy has a wholesale dealer's license enabling it supply aesthetic products as stock. This activity is regulated by the Medicines and Healthcare products Regulatory Agency and so outside the scope of this inspection.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 identifies and manages the risks associated with its services in an effective manner. It keeps the records it needs to by law and takes the necessary steps to keep people's information safe. Its team members make a record of mistakes that happen so that they can learn from them. And they make some additional checks when dispensing prescriptions for aesthetic products to help make sure the supplies are legally valid. Members of the team are aware of how to keep vulnerable people safe.

Inspector's evidence

The pharmacy team had access to electronic standard operating procedures (SOPs) available on a shared drive. These covered the operational activities of the pharmacy and the services provided. SOPs appeared to have been periodically reviewed and new SOPs were available when processes had changed. Team members had read and agreed the SOPs that were relevant to their role.

The pharmacy held an NHS contract but dispensed very few NHS prescriptions. And its over-the-counter medicines sales were also low. Its main activity was dispensing prescriptions to approved and validated healthcare professionals within the aesthetic market.s. The service was provided through its website www.healthxchange.com. The website offered a wide range of aesthetic and skincare products, including some medicines, and associated consumables, such as syringes and gloves, for use alongside aesthetic treatments. The pharmacy supplied these products to healthcare professionals and clinics based in the UK.

Healthcare professionals wanting to order products or send a prescription to the pharmacy were required to register an account through the website before requesting supplies. The pharmacy did not supply aesthetics products directly to the general public. Only UK based healthcare professionals qualified to prescribe were eligible to register for access to the service. The pharmacy permitted other non-prescribing healthcare professionals to register but they could only order a limited range of products such as non-prescription medical devices, skin treatments and consumables. Individuals were required to supply specific proof of their identity when registering. A check was carried out to verify the information provided and a record of this check was kept. The pharmacy completed a check of the prescriber's registration status to help make sure they were still able to prescribe and did not have any restrictions placed on their license. A small number of checks were completed each day on a rolling basis and a record was maintained. In some cases, the pharmacist explained that the prescriber was also required to provide proof of training when prescribing specific treatments so that an assurance of their competency was provided.

Healthcare professionals qualified to prescribe were able to generate electronic prescriptions using their account details using the 'e-pharmacy platform' on the website. The pharmacy had a Wholesale Dealers Authorisation (WDA) but most products were supplied on prescriptions for named individuals which included botulinum toxins, dermal fillers and other specialist skin treatments. Prescription orders were usually delivered to the prescriber's address or the clinic where they worked.

Some steps were taken to identify the risks identified with the aesthetic services. Audits were

completed to assess dispensing errors and take steps to help reduce the risk of dispensing errors. Another monthly audit included a mock medicine recall which allowed the superintendent pharmacist (SI) to make sure recalls were being actioned appropriately. The pharmacy also required prescribers to confirm that consultations were being completed face to face rather than remotely.

The pharmacy maintained a record of near misses on a near miss log. This is when a mistake is identified upon completion of an accuracy check. The mistake was highlighted to the team member involved and they were required to identify the mistake as part of the learning process. They corrected the mistake and made a record on the near miss log. The log was completed regularly and it was reviewed during a weekly pharmacist meeting and as part of a monthly audit. The RP explained that common trends and learning identified by the review were shared with the team. An example of a recent learning involved team members separating different batches of similar looking medicines to prevent them getting mixed up. The pharmacy had a process in place for recording and reporting dispensing errors. This is when a dispensing mistake occurs but is not identified before the medicine is supplied to people. A record of any errors was made which was shared with the superintendent pharmacist (SI) so they could be reviewed.

The pharmacy had a complaints procedure that its team members were aware of. An internal email inbox was used to accept complaints and feedback which would then be shared with the pharmacy. But the process to make a complaint was not clearly advertised either in the pharmacy or on its website so people may not understand how they can make a complaint following a service they had received. The pharmacy had professional indemnity insurance to cover the services that it provided.

The pharmacy maintained the records it needed to by law. The responsible pharmacist (RP) notice was clearly displayed, and the RP record complied with requirements. The pharmacy operated two separate PMR systems. One was used to keep records of the prescriptions dispensed for the aesthetics service and the other was used for all other prescriptions. A private prescription register relating to aesthetic supplies was available and stored the details that were required. Records of supplies of unlicensed medicines were kept and included details of the person receiving the medicine. The pharmacy also maintained a record of controlled drugs (CDs) that had been received and supplied. The number of CDs being dispensed was very low. Running balances were recorded and were checked regularly.

There was a privacy policy on the pharmacy's website which contained information about website security, and this was also included on the 'frequently asked question' (FAQ) page. Confidential waste was stored separately and disposed of securely. The pharmacists had completed level three safeguarding training and team members were aware of the process to follow if a safeguarding concern was identified.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to safely manage the workload and the services that it provides. Members of the team have the right qualifications for their roles, they feel well supported by their colleagues and managers, and can raise concerns.

Inspector's evidence

The pharmacy team consisted of two regular full-time pharmacists, three qualified dispensers, one of whom had completed additional training and worked as an accuracy checker (ACD), and two dispatchers who were medicine counter assistant trained. Two of the dispensers were currently training to become ACDs. Holidays were planned to make sure there was enough staff cover. The workload appeared to be manageable, and orders were generally dispatched the same day they were received. Pharmacy team members completed role specific tasks and the dispatchers completed administrative duties and packed orders ready for collection by couriers.

Members of the team had completed some training tailored to the services they offered and the pharmacy occasionally provided the team members with opportunities to attend some of the company wide training events. The pharmacist explained that they had recently attended a training day about the electronic system they used to process the electronic prescriptions and was planning on sharing the information with the team. Those currently on training courses felt well supported by the RP and other team members when completing the learning. And they were provided with protected time.

Pharmacy team members communicated openly and felt able to raise concerns with the pharmacists. They could contact a member of the management team or superintendent if they wanted to discuss anything with them directly. Annual appraisals were completed with individual members of the team to discuss their performance and to help identify any training needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure, and professional environment for the provision of its services. The website contains useful information about the aesthetic service and the pharmacy.

Inspector's evidence

The pharmacy was clean, organised and well lit. It had climate control to help maintain the room temperature at a suitable level. Its team members cleaned the pharmacy daily. The dispensary area was behind the front counter and unauthorised access was restricted. There was adequate bench space to safely assemble prescriptions.

A consultation room was available for people to have a private conversation or receive a pharmacy service. It was clean and tidy which helped maintain a professional appearance. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible and suitably managed. It obtains its medicines from licensed suppliers and stores them appropriately. And it carries out checks to make sure they are safe to people to use.

Inspector's evidence

The pharmacy provided its services Monday to Friday and access to the premises was step free via a manual door. The opening hours of the pharmacy were shown on the entrance and people could contact the pharmacy by telephone or email. The pharmacy stocked a small range of OTC medicines and pharmacy medicines were stored behind the counter to prevent unauthorised access.

The pharmacy's computer system was integrated with the electronic prescription ordering system. Most aesthetic prescriptions were generated using the electronic prescribing function of the pharmacy's website. The system could restrict which products each person could order depending on their registration profile. Generated prescriptions contained all the required information and were allocated to the pharmacy by the customer service team. Prescriptions and invoices and labels were printed so the pharmacy team could refer to these when dispensing. Dispensers selected and labelled the products, and they were passed on to the pharmacists who completed clinical and accuracy checks. In some cases, the accuracy check was completed by an ACD. In these instances, the ACD would first check that the pharmacist had completed the clinical check and signed the prescription to indicate this. Team members signed the paperwork when dispensing and checking so there was an audit trail of the team members involved.

The pharmacy had recently made some changes to the computer system so that the pharmacist had access to a patient's ordering history. This allowed them to complete a thorough clinical check to help make sure that the prescription was appropriate and safe for the person receiving the treatment. If the pharmacist had a prescription query, they would usually contact the prescriber by email and request a direct response. The pharmacists could recollect an occasion when they had queried unusual prescribing where the prescriber had requested a large amount of botulinum toxins that had exceeded the limit set by the pharmacy. In this case, the RP contacted the prescriber, and the prescription was amended but a record of intervention was not made. The pharmacy did not usually have any direct contact with people prescribed aesthetic treatments and resolved issues with the clinic or prescriber involved in their care. Prescribers could issue prescriptions for adjunct treatments on prescription such as creams and antibiotics. Occasionally other prescription medicines such as benzodiazepines were requested but the pharmacists said this was rare and they would query any unusual prescribing. Schedule 2 and 3 CDs could not be prescribed using the e- pharmacy platform. Prescriptions were sometimes delivered to the patient's home. For example, non-aesthetic topical creams for self-administration.

Once prescriptions had been checked and approved by the pharmacists, they were passed on to the dispatch team. Orders were photographed before they were sealed ready for dispatch. This meant the team could refer to the photographs if there were queries about order quantities or products. Prescriptions were delivered using a tracked 24-hour courier service. Fridge items were packed in specially designed boxes with ice packs to ensure the contents were kept at the required temperature.

The pharmacist explained the delivery packaging was validated monthly to check the temperature was maintained over various journey distances and fluctuations in outside temperature.

The pharmacy supplied some medicines to people in accordance with NHS prescriptions. The volume of dispensing was very low, and it tended to be supplied to people that were visiting the city. It occasionally supplied some CDs on NHS prescriptions and members of the team were aware of the 28-day legal validity. The pharmacist was also aware of the risks of taking valproate and isotretinoin and the need for a Pregnancy Prevention Programme for people who were at risk. The pharmacy supplied isotretinoin for some patients through its aesthetic service. Prescribers confirmed when prescribing that a pregnancy test had been completed if relevant and patients had signed a consent form when commencing treatment. The pharmacy did not supply valproate containing medicines to anyone, but it had educational materials available, and the pharmacist was aware of the requirement to supply the medicines in the original pack.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. Its team members checked the expiry dates of medicines on a rolling basis which was determined by the pharmacy stock system. The expiry dates of some medicines were checked, and none were found to be expired. Medicines with special storage requirements were stored appropriately. CDs were stored in a secure cabinet. Medicines that required cold storage conditions were stored in a suitable fridge. The temperature of the fridge was seen to be in the required range and the pharmacy kept a daily record of the temperatures. The pharmacy received drug alerts and safety recalls by email and electronically within the pharmacy computer. Its team members checked the pharmacy for any affected stock and made a record of the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment that it needs to provide its services. And it uses it in a way to protect people's private information.

Inspector's evidence

The pharmacist accessed the internet for appropriate reference sources such as the BNF. There were four medical fridges for storing medicines and freezers for storing cold packs and the pharmacy had a suitably secured CD cabinet. There were packaging materials for dispatching medicines, including cold packs and insulated materials for refrigerated items. All electrical equipment appeared to be in working order. Computer systems were password protected and each team members had their own log-in to the IT systems. Computer screens were not visible from the public area.

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.