General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Teleta Pharma Ltd, Unit 4 Cairn Court, Nerston Industrial Estate, East Kilbride, Glasgow, South Lanarkshire, G74 4NB

Pharmacy reference: 9011283

Type of pharmacy: Internet / distance selling

Date of inspection: 23/04/2024

Pharmacy context

This is an internet-based pharmacy situated within a wholesaler's premises in a business park in East Kilbride on the outskirts of Glasgow. Its main activity is dispensing aesthetic products and other medicines prescribed privately by a range of different healthcare professionals including doctors, nurses and pharmacists. The majority of medicines are delivered by selected couriers, but some practitioners collect the medicines directly from the pharmacy.

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 properly assess and manage the risks with all its services. Its risk assessments do not cover all of the medicines it supplies. This includes for weight loss medicines and medicines being used outside of the manufacturer's product licence.
		1.2	Standard not met	The pharmacy does not complete audits of its services to make sure it delivers them safely and to make sure it supplies products in accordance with its procedures. And it does not monitor prescribing and supplies to prompt effective interventions of overprescribing and inappropriate supply.
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 not all met	4.2	Standard not met	The pharmacy does not have adequate safeguards to ensure the safe and effective delivery of its services. It does not have information from prescribers to allow for adequate pharmacist clinical checks and to make sure the medicines it supplies are safe and appropriate for people.
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 identify and manage all the risks for the services it provides. It assesses some risks through its written risk assessments. But these are not complete and do not cover its supplies of some of the higher-risk medicines. And the pharmacy does not actively review or monitor its services to ensure it provides them safely. It does not have systems to effectively identify and challenge overprescribing and oversupply. Team members record mistakes they make during the dispensing process, and they make changes to help prevent a similar mistake occurring. They generally keep complete records required by law and they keep people's private information secure. They know how to respond to concerns about the welfare of vulnerable people.

Inspector's evidence

The pharmacy provided its services privately via its website, www.teleta.co.uk. It provided a range of non-surgical cosmetic treatments including prescription only medicines (POMs) such as botulinum toxins and other associated products. It also supplied injectable medicines to people for weight loss against private prescriptions. To use the pharmacy's website, prescribers and aesthetics practitioners were required to register an account with the website. Pharmacy team members verified each prescriber and practitioner. The pharmacy required prescribers and practitioners to provide proof of their identity and address when they registered with the website to confirm they were based in the UK. Pharmacy team members checked prescribers' professional registration information to confirm they had the necessary accreditation to prescribe and to confirm they were not subject to any conditions or restrictions on their prescribing practices. And they did this every three months for each prescriber. The pharmacy did not ask prescribers to provide evidence of their training or competence to prescribe for aesthetics and weight management. Non-medical aesthetic practitioners required a prescription from a prescriber that the practitioner had a pre-existing relationship with. The pharmacy did not ask practitioners to provide proof of their competence or training. And it did not request information from prescribers or practitioners about their professional indemnity insurance arrangements. When it supplied botulinum toxins, the pharmacy required prescribers to submit the date of the latest physical face-to-face consultation completed by the prescriber, in accordance with GPhC guidance and guidance published by the Joint Council for Cosmetic Practitioners (JCCP). But the pharmacy did not take steps to verify this information and was reliant on self-declaration by the prescriber.

The pharmacy had current standard operating procedures (SOPs) which included SOPs about the responsible pharmacist (RP), dispensing, delivery and complaints. Team members had signed the SOPs to confirm they understood and would comply with them. The pharmacy had carried out some risk assessments for the private services it provided. These considered the risks involved with some of the medicines it supplied. The pharmacist had identified that supplying medicines for intravenous use was higher-risk and addressed this risk by requiring the prescriber to provide evidence of indemnity cover for these specific treatments. And they had put limits on quantities for certain medicines to help prevent inappropriate use. The pharmacy did not dispense medication for people under the age of eighteen. The pharmacy regularly supplied injectable weight loss medicines to people. And risk assessments did not consider any requirements for ongoing monitoring to establish if repeated supplies were safe and appropriate. And the pharmacy made no checks to establish the prescribing policies being used by the prescribers that used its website. It therefore had limited information from the prescriber to help complete a full clinical assessment of each prescription it received for these

medicines.

The pharmacy did not carry out any audits of the services it provided, or on the supplies of medicines it made to people using these services. It did not have a process to review if the safeguards they had put in place following its risk assessments were effective. So, there was no process to identify prescribing trends that would be appropriate for intervention. The pharmacy did not record clinically significant information to establish whether supplies were appropriate for people, for example asking for and recording people's BMI to establish if a supply of a weight loss medicines was appropriate. This meant that the pharmacist did not have access to information to help make a proper and accurate clinical assessment of a prescription.

The pharmacy recorded mistakes identified and rectified during the dispensing process, known as near misses. The team member responsible for the near miss recorded the details about it and discussed it informally with the pharmacist. Team members had separated medicines that had been identified by a dispenser as being involved frequently in near misses. And the pharmacy completed a monthly review of identified trends to reduce the risk of repeated mistakes. The pharmacy completed incident reports for mistakes that were not identified until after a person had received their medicine, known as dispensing errors. Team members had a procedure for dealing with complaints. They completed a customer complaint investigation checklist and the superintendent pharmacist (SI) worked in the pharmacy so was available to resolve any complaints that required escalation.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. The RP notice was prominently displayed in the pharmacy and reflected the details of the RP on duty. The RP record was completed correctly with the details of the RP on duty, but from the sample seen several entries did not include the time the RP ceased duty. The pharmacy kept complete electronic records for supplies of medicines made against private prescriptions and retained the corresponding prescriptions. Team members were aware of their responsibility for ensuring that people’s private information was kept securely. They kept confidential waste separately and shredded it on site within the pharmacy. Team members also knew of their responsibilities to safeguard vulnerable people accessing the services. The pharmacist raised any concerns with the prescribers through the customer service team. And they were registered with the Protecting Vulnerable Groups (PVG) scheme. The pharmacy only supplied to people over the age of eighteen. But it did not carry out any verification of the information provided by prescribers and were instead reliant on the prescribers and practitioners identification process being robust.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified team members to help manage its workload safely. Team members complete on going training to develop their skills and knowledge about the products they dispense.

Inspector's evidence

At the time of the inspection the RP was the SI, and they were supported by two dispensers. Other team members not present included two dispensers, one of whom worked mainly for the customer services team. The pharmacy had a small customer service team who mainly dealt with sales and contacted prescribers and practitioners on behalf of the RP. One of the customer services team was also an aesthetics practitioner.

Team members had completed accredited training for their roles. The SI had not completed any formal training in aesthetics but provided links to the JCCP or referred the practitioners to their training provider if advice was required. Team members were observed supporting each other and they were managing the workload. Annual leave was planned in advance so that contingency arrangements were made. The pharmacy used a regular locum pharmacist to cover annual leave. They had shadowed the SI to gain experience of working with aesthetics. And some of the customer service team had completed accredited qualification training and assisted in the dispensary when required. This included a dispenser and a registered pharmacy technician.

Team members received ongoing training from the commercial director about new products which was provided by the manufacturers. There was an open and honest culture amongst the team. The pharmacy did not set targets for its team members and team members did not receive annual performance reviews.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean and suitable for the services it provides. The pharmacy's website is clearly laid out, but it doesn't make it clear who has authority to obtain products through its website which may cause confusion to the public.

Inspector's evidence

The pharmacy's website, www.teleta.co.uk was used by prescribers and practitioners to submit private prescriptions for medicines, injectable and oral weight loss medicines and non-surgical cosmetic treatments, such as toxins, fillers, medicines, and ancillary items. Medicines and treatments could only be requested by prescribers and practitioners who were registered with the pharmacy. There was no access to treatments for the public. But this was not made clear to people accessing the website and may cause confusion. The pharmacy's website provided details about the owners, its physical location and contact details. And it provided the name and registration details of the SI.

The pharmacy premises were based in a locked area within a larger warehouse associated with the company's wholesale operation. And it was not possible to access the pharmacy without a team member present. The pharmacy was spacious and had a good workflow with separate bench spaces for the completion of different tasks. It was tidy and organised, with medicines arranged neatly on shelves. It had a sink which provided hot and cold water. Toilet facilities were clean and provided separate facilities for handwashing. Team members cleaned the pharmacy according to a rota which was up to date. The temperature was comfortable, and the lighting provided good visibility throughout.

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

Summary findings

The pharmacy does not have adequate safeguards to ensure it delivers its services safely. It does not make adequate checks to ensure it supplies medicines that are safe and clinically appropriate for people using these services. Team members generally store medicines as they should. They complete suitable checks to ensure medicines remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy was closed to the public, although some practitioners were able to collect their prescriptions in person. People were asked to wait at the reception area and a member of the pharmacy team brought their medicines to them. And they completed appropriate checks to ensure they were being given to the correct person. The pharmacy's customer services team was contactable by telephone and email. Most of the private prescriptions dispensed by the pharmacy were generated electronically using the pharmacy's website. Prescribers had their own unique log on and generated an electronic prescription on the system. This was processed by a dispenser who printed the prescription, shipping label and generated a dispensing label for the products requested. When discussing the electronic signature, the pharmacy described the code that was used to define the individual prescriber and how the authorisation could only be used once.

The pharmacist asked the customer service team to contact prescribers if there were any issues with the prescriptions submitted. These issues were usually around prescription requirements such as typing errors. Team members kept a log of these communications to refer to. But the pharmacist did not keep records of any clinical interventions they made. The pharmacy frequently dispensed medicines to people for weight loss. It did not request or record any clinical or monitoring information from prescribers to determine whether the medicines were appropriate for people. Or whether people had achieved the necessary weight loss required to justify ongoing prescribing and supply of the treatment. The pharmacy did not request to see any prescribing policies from the prescribers it worked with. So, it was difficult for the pharmacy team to determine if prescribers applied appropriate checks to ensure safe prescribing and ongoing monitoring. And the pharmacy did not ask for any information as to whether prescribers informed people's NHS prescribers of any treatment to ensure joined up care. Pharmacy team members were aware of national guidance that Ozempic and Rybelsus should currently only be prescribed for their licensed indication for diabetes. But records showed the pharmacy had continued to dispense these medicines with no recorded contact with the prescribers or assessment of risk.

The pharmacy had identified maximum quantities and frequencies for certain medicines, such as botulinum toxins, that could be prescribed at one time. But the data of the supplies the pharmacy had made provided several examples of prescribing that would have been appropriate for intervention by the pharmacy. These included supplies of botulinum toxin with quantities and frequencies greater than the limits the pharmacy stated in their risk assessments. These trends had not been noticed or queried by the pharmacist or other pharmacy team members. So, the pharmacy was unable to establish the safety and quality of the services it provided. Many prescriptions contained the directions "Use as directed". This included medicines that were being supplied outside of the manufacturer's product license, such as Ozempic and Rybelsus for weight loss, and for injectable botulinum toxins for cosmetic

purposes. The lack of directions made it difficult to determine if the supply was appropriate. And the lack of clear instructions increased the risks of inappropriate use by people. There was also evidence of prescribers prescribing botulinum toxin for people and practitioners across a very wide spread of geographical locations across the UK. This had not been queried by the pharmacy to ensure that physical face-to-face consultations were taking place.

Prescriptions dispensed through the pharmacy's website were delivered using a national courier service. The pharmacy had processes in place to make sure cold-chain items were transported at the correct temperature. These items were packed in boxes containing cold packs and insulating materials. The packages were clearly labelled as cold-chain items. And they were dispatched using a tracked service. Packages containing items that required cold storage were not supplied on Friday due to the pharmacy being closed over the weekend. The pharmacy had tested the integrity of cold-chain packaging by monitoring the inside of a packed box over 24 hours. It showed the package had been maintained at the expected temperature. The pharmacy was alerted to any dispatched deliveries that were not delivered within 24 hours by the courier, so they could be recalled to the pharmacy and the products disposed of.

The pharmacy team members used trays to keep people's prescriptions and medicines together and prevent them becoming mixed up. They signed dispensing labels to confirm who had dispensed the item and who had checked it so an audit trail of who was involved in the dispensing process was kept. Team members kept prescriptions with medicines owed for six months. They explained that practitioners sometimes requested that only part of the prescription be dispensed and alerted the team when they required the remainder. At this point, team members checked to ensure that a recent face-to-face consultation had taken place, and if not, this was requested before the items were issued. For any items that were out of stock, alternatives were requested from the prescriber.

The pharmacy sourced its medicines from licensed wholesalers. Team members checked the expiry date of medicines. A report was generated that showed which medicines were going out of date in the next forty-five days. Medicines that had expired were disposed of in yellow clinical waste bins in the busy warehouse, which was not under the supervision of the pharmacy. Team members confirmed they had records of the medicines that were in the clinical waste bins for destruction but would not be aware if medicines had been removed. During the inspection a team member secured the lid of one of the bins. Team members recorded the temperatures of the pharmacy's fridge daily. And records showed the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email. These were printed and actioned by team members.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has access to appropriate reference sources to support the dispensing process. It's facilities protect people's private information.

Inspector's evidence

The pharmacy has access to up-to-date electronic reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). But team members could not demonstrate access to resources about veterinary medicines they supplied on an infrequent basis.

The pharmacy used discreet packaging for deliveries which meant that people were unable to identify the medicines that were contained within the packages. Team members used passwords to access computers and telephone calls were answered within the pharmacy premises, so they were kept private. The pharmacies records, including paper prescriptions were kept in boxes within the pharmacy which was locked when not in use.

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.