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: 21/11/2024

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 activities are dispensing aesthetic products and weight loss medicines prescribed privately. The majority of medicines are delivered by selected couriers, but some people and practitioners collect medicines directly from the pharmacy.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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's written procedures help team members to manage risk and deliver services safely. And its risk assessments help identify and mitigate risks associated with the services it provides. Team members record mistakes made during the dispensing process and make changes to help learn from them. They generally keep the records required by law. They keep people's private information secure. And they know how to respond to concerns for the welfare of vulnerable people. They complete some checks of prescribers and practitioners training, but they do not ask for prescribing policies to ensure that prescribers are prescribing safely and effectively.

Inspector's evidence

The pharmacy had current standard operating procedures (SOPs) which had been reviewed by the superintendent pharmacist (SI) in April 2024. These included SOPs about the responsible pharmacist (RP), delivery and receiving and dispensing prescriptions. Team members had signed to say they had read and understood the SOPs in the last year. There was no documented procedure about date checking of pharmacy stock, but team members followed a procedure to ensure date checking was completed.

The pharmacy required prescribers and aesthetics practitioners to register an account with its website. And they were required to provide photographic identification to confirm their identity. The pharmacy checked prescribers' professional registration information with the appropriate regulator to confirm they had the necessary accreditation to prescribe. And they completed ongoing checks of the prescriber's registration status every three months. The pharmacy currently did not ask for proof of indemnity insurance when prescribers registered an account with them. Instead, they completed checks of selected prescriber and practitioners' indemnity insurance monthly. And they recorded outcomes of these checks. For higher risk medicines such as those administered intravenously, prescribers were asked to provide indemnity insurance before prescriptions were dispensed. The pharmacy was due to implement a prescriber and practitioner verification process on its website from February 2025. This meant that any prescribers or practitioners who registered an account with the pharmacy had to provide details upfront of their training, indemnity insurance and any prescribing policies. The pharmacy did not currently ask prescribers to provide prescribing policies but made some checks on training for prescribers and practitioners. The SI had emailed prescribers good practice guidelines about prescribing cosmetic products and had written a blog about the guidelines on the pharmacy's website. Prescribers and practitioners who were currently registered with the pharmacy would also complete the new verification process in time once it was live.

The pharmacy had risk assessments (RA) for its services. This had been completed in response to the previous inspection. It had assessed the risks of providing non-surgical cosmetic products which included toxins such as botulinum toxin. The RA identified risks such as ensuring that guidelines about good prescribing practice by the Joint Council for Cosmetic Practitioners (JCCP) were followed by the prescribers who provided the prescriptions for practitioners to administer. And a sample of prescriptions seen generally showed that the guidelines were being followed by the prescribers. The pharmacy asked prescribers to annotate the prescription with the date that a face-to-face consultation had taken place with the person they were prescribing for. At the previous inspection, the pharmacy had not independently verified that face-to-face consultations were taking place. The pharmacy now completed checks to ensure this was taking place by selecting a sample of prescriptions and verifying

with the person that a face-to-face consultation had taken place. The pharmacy identified in its RA maximum quantities for its aesthetic products prescribed. And instances of overprescribing were queried, and a clinical intervention was recorded. Evidence that the pharmacy had identified and rejected prescriptions where oversupply had been identified were seen, including for toxins. The pharmacy had a clinical intervention log which detailed some information about the intervention made, such as the prescriber and details of the intervention and the outcome of the intervention. The clinical intervention logs also showed that team members queried and rejected prescriptions that were deemed to be prescribed too frequently.

The pharmacy had identified that the prescribing of weight loss medicines was higher risk. And they had included risk reduction measures on the RA which included checking there was a documented BMI on the prescription, and any queries about dose strength or frequencies were queried and recorded. Again, evidence of interventions about doses queried with prescribers was seen. Team members also recorded people's BMIs on the patient medication record (PMR) and monitored that it was reducing appropriately. The pharmacy identified the risks associated with providing medicines that were not used for their licensed indication, known as "off label". And they had determined various risk reduction measures, including a maximum quantity of Kenalog vials allowed on prescription, and that prescribers were required to agree to wording on the prescription that they were aware of the off-label use of the medicine. Evidence that a prescriber had been asked by the SI to confirm that they and the people they were prescribing to were aware of a medicine being used off label was seen. And the prescriber had confirmed this.

The pharmacy completed various audit reviews. These included clinical intervention audits, and reviews of the checks of prescriber and practitioners' insurances. The clinical intervention audit detailed the most common type of clinical intervention, such as querying doses with prescribers for weight loss medicines or querying instances of overprescribing. And it detailed outcomes of the clinical audit, such as emails sent to prescribers about good prescribing practices for cosmetic products. Clinical intervention audits were completed monthly and showed a downward trend in the volume of clinical interventions being made. The pharmacy confirmed this was because they had seen an improvement in prescribers annotating prescriptions with directions for people and therefore fewer interventions were needed. The pharmacy had also completed an audit of ten weight loss prescriptions which identified whether BMIs were provided on prescription and whether prescribers were following prescribing protocols and dispensing the lowest dose initially. If this was not the case, the pharmacist queried this with the prescriber and evidence of the clinical interventions were seen. The pharmacy also completed audits of the numbers of prescriber and practitioner indemnity insurance checked over the past three months, with findings. And they audited the numbers of people asked to confirm face-to-face consultations for aesthetics had taken place.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. Near misses were recorded when identified. And they were discussed with the team member involved. The pharmacist completed a monthly review of the near misses made which identified trends and potential reasons for the mistakes. Team members had separated medicines involved in repeated near misses from each other to try and prevent them from being incorrectly selected again. The pharmacy completed reports for errors identified after the person had received their medicine, known as dispensing incidents. The reports were completed by the SI and identified the root causes of the error and steps taken to prevent the error from occurring again – including separating the affected products on the shelves. Team members had a procedure for dealing with complaints. They completed a customer complaint investigation checklist and the 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 did not always 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. A sample of three prescriptions checked corresponded with the entries in the register. Team members were aware of their responsibility for ensuring people's private information was kept securely. They kept confidential waste separately and shredded it on site within the pharmacy. Team members were also aware of their responsibilities to safeguard vulnerable people accessing the pharmacy's services. And they had a SOP to refer to if needed. Any concerns were referred to the pharmacist. The pharmacist was registered with the protecting vulnerable groups scheme (PVG). The pharmacy did not dispense any medication for people under the age of 18. However, it dispensed some stock orders of medicines including toxins from prescribers which were not for named people. So, it may not be able to always assure itself of who the products were being supplied to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified team members to help manage its workload safely. Team members complete ongoing 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. And a pharmacy technician, who mainly worked for the customer services team, assisted in the dispensary when needed. Annual leave was planned advance and part-time team members could increase their hours to support periods of absence. Annual leave for the SI, who was the full-time pharmacist, was covered by two locum pharmacists who had gained experience of the specialist services provided by shadowing the SI and completing reading such as the guidelines produced by the JCCP.

Team members completed ongoing training about the services they provided. For example, they had recently completed training provided by the Centre for Pharmacy Postgraduate Education (CPPE) about weight management for adults. For any new products the pharmacy supplied, the company’s sales team provided information from the manufacturers about the products. Team members received annual appraisals from the SI. And they had been completed this year. There was an open and honest culture amongst the team, and they felt comfortable discussing their mistakes. The SI had an informal meeting each week with team members to discuss any issues, product recalls and the outcome of any audits. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean and suitable for the services it provides. The pharmacy's website details various products it supplies. But it does not always make it clear when medicines are supplied by the pharmacy and when they are supplied by the wholesaler.

Inspector's evidence

The pharmacy's website, www.teleta.co.uk, was used by prescribers and practitioners to submit private prescriptions for non-surgical cosmetic products including toxins, fillers, medicines and ancillary items and injectable and oral weight loss medicines. Medicines that were prescription only could only be supplied via prescription. And they were marked as such on the website. Other non-prescription products such as some fillers and other products could be purchased directly from the website or could be supplied via prescription. The SI confirmed that when a product was purchased from the website, it was being supplied by the wholesaler, and not the pharmacy. The website did not make this clear, which may cause confusion for those using the website. The website displayed the correct details of the SI, their registration number and the registration number of the pharmacy. And it provided details about the owners and its physical location.

The pharmacy premises were based in a locked area within a larger warehouse associated with the company's wholesale operation. It was not possible to access the pharmacy without a team member present. The pharmacy had different bench spaces for the completion of different tasks. And the pharmacist had a defined checking area which allowed them to supervise the pharmacy. The pharmacy was tidy and organised with medicines arranged neatly on shelves. And team members kept the dispensary clean according to a rota which was up to date. There was a sink in the pharmacy which provided hot and cold water for handwashing. Lighting provided good visibility throughout and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely. It packages medicines appropriately for delivery to ensure they are suitable for people to use. Team members query instances of overprescribing to ensure that people are receiving medicines and products safely. They complete checks on medicines to ensure they remain fit for supply. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy was closed to the public, although some practitioners could 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. Some people occasionally collected their own prescriptions for weight loss injections directly from the pharmacy. And team members completed suitable checks to ensure that medicines were being given to the correct person. The pharmacy was contactable by telephone and email through the customer services team and people could contact the pharmacy for advice about their medicines. The majority of the pharmacy's prescriptions were generated electronically using the pharmacy's website. The dispensers printed the prescriptions and generated dispensing labels through the PMR system. Team members used baskets to keep people's prescriptions and medicines together to help reduce the risk of error. And team members signed dispensing labels so there was an audit check of who had dispensed and who had checked the medicines.

As part of improvements from the last inspection, the pharmacy recorded discussions with prescribers about clinical queries. Records of email conversations querying doses of weight loss injections or querying what a person's BMI were seen. And they had queried with some prescribers as to whether face-to-face consultations were taking place, in addition to independently verifying with people who the prescriptions were for. And they had recorded details of a conversation had with a prescriber about ensuring they, and their patients, were aware a medicine had been prescribed "off label". The pharmacy confirmed they had spoken to prescribers to inform them about ensuring a person's regular GP was informed of any medicine prescribed privately. But they did not make any checks to ensure this was occurring.

The pharmacy had identified maximum quantities for certain medicines including botulinum toxins. Evidence showed that instances of overprescribing had been queried with prescribers and rejected where it was deemed that overprescribing had occurred. And a sample of PMR data seen showed that prescriptions for toxins dispensed were below the maximum quantities. The pharmacist had developed a flow chart to assist team members with decision making about whether toxins were supplied too frequently. Team members also recorded instances of querying and resolving issues with prescriptions such as those that were missing aspects of people's information, such as date of birth or addresses. And examples of queries about doses of injectable weight loss medicines were seen, including either further information about treatment the person had already received, or new prescriptions issued. The pharmacy asked prescribers to write directions for botulinum toxins when the administration of them was delegated to a practitioner. And a sample of prescriptions seen showed that prescribers were generally annotating their prescriptions with the directions.

Prescriptions dispensed by the pharmacy were delivered using national couriers. Non-surgical aesthetic products were delivered to practitioners and not the person receiving the treatment. The pharmacy

packaged medicines requiring cold chain storage in insulated bags between ice packs. The pharmacy had tested the temperature of the products during delivery by adding a thermometer to measure the temperatures over 24 hours. And it showed that the medicines were kept at the expected temperatures.

The pharmacy sourced its medicines from licensed wholesalers. It had a process for checking the expiry date of its stock. All medicines received by the pharmacy were inputted into the system with their batch number and expiry date. The operations director alerted team members monthly about medicines that were due to expire in the next few months. And team members had identified the most recently highlighted medicines on the alert and kept them separately. Team members communicated with the operations director when medicines were removed for destruction. The pharmacy had a fridge for the storage of medicines that were required to be stored within two and eight degrees Celsius. Team members recorded the temperatures of the fridge daily and recorded action taken if the temperature deviated outside the required temperatures. Team members received notifications about drug alerts and recalls via email. They printed them and signed to say action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has access to appropriate reference sources to support the dispensing process. Medicines are discreetly packaged and kept at appropriate storage conditions during delivery. The pharmacy's facilities protect people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference resources including the British National Formulary (BNF) and JCCP guidelines. Team members could not demonstrate access to resources about veterinary medicines they supplied on an infrequent basis, which was the same as at the previous inspection.

The pharmacy used plain packaging for deliveries which did not identify that medicines were contained within. 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.