General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hexpress Healthcare Ltd, 106 Lower Addiscombe Road, Croydon, CR0 6AD

Pharmacy reference: 9011703

Type of pharmacy: Internet / distance selling

Date of inspection: 20/05/2022

Pharmacy context

The pharmacy offers services to people through the websites - www.healthexpress.co.uk and www.onlineclinic.co.uk. It doesn't provide any NHS services. And people who use it aren't allowed to visit its premises in person. The websites allow people to access a prescribing service which offers prescription medicines for a wide range of conditions. The prescribing service is mainly provided by doctors registered with the General Medical Council (GMC) and is regulated and inspected by the Care Quality Commission (CQC). The pharmacy mostly supplies medicines to people living in the United Kingdom (UK). But it supplies some medicines to people living outside of the UK too. The inspection took place during the coronavirus (COVID-19) pandemic.

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 generally manages its risks. And it mostly has the procedures it needs to help its team work safely. Members of the pharmacy team know what they can and can't do, what they're responsible for and when they might seek help. They adequately review the safety of the services they deliver. They understand their role in protecting vulnerable people. And they keep people's private information safe. People using the pharmacy can provide feedback to help improve its services. And the pharmacy keeps the records it needs to by law.

Inspector's evidence

The company offered an online prescribing service. Its websites offered treatments for men's health, women's health, sexual health, chronic conditions, travel medicines and lifestyle medicines (including smoking cessation and weight loss). And the quality and the safety of the prescribing service was regulated and inspected by the CQC. The prescribing service was provided by doctors. And it was overseen by a CQC registered manager who was a GMC registered doctor and the company's clinical lead. The prescribers weren't based at the pharmacy, and they worked remotely or at the company's head office. The company had written risk assessments and policies for the services it provided such as its prescribing service. And it had a corporate risk register too. But it could do more to make sure all the risks associated with the pharmacy services were documented, managed and included in its risk register. The company had recently started to use European registered doctors in addition to its GMC registered doctors to prescribe medicines for people living in the UK due to clinical staff shortages. But they were already familiar with the company's policies and systems. They knew what they could and couldn't prescribe. And, for example, they didn't prescribe for certain conditions or medicines. The company oversaw the quality of their prescribing.

The pharmacy had up-to-date standard operating procedures (SOPs) for most of the services it provided. But the pharmacy procedures needed to be reviewed to make sure they met the requirements of The Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. Members of the pharmacy team had considered the risks of coronavirus. They were encouraged to self-test for COVID-19. They had the personal protective equipment they needed. And hand sanitising gel was freely available. The pharmacy was spacious which allowed team members to socially distance from each other.

The pharmacy had systems to record and review the mistakes its team made. Members of the pharmacy team were required to reflect upon the mistakes they made to help spot the cause of them and share any learning outcomes from them with each other. So, they could try to stop the same types of mistakes happening again. And, for example, the pharmacy team decided to only stock the smallest pack size of an erectile dysfunction medicine following mistakes when the wrong pack size was selected. The company decided to stop supplying a medicine that could lower a person's blood pressure following attempts by people to obtain and use the medicine inappropriately. The pharmacy displayed a notice that identified who the responsible pharmacist (RP) was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their responsibilities were described in the SOPs. The pharmacy had a complaints procedure and there was a customer service team to help people too. And the websites told people how they could provide

feedback about the company or its services. The company reviewed the configuration of its websites following feedback from the GPhC. The superintendent pharmacist had recently reviewed what additional information people needed on how to take or use their prescribed medication following a concern from a patient who misunderstood the instructions they were given.

The pharmacy had insurance in place, including professional indemnity, for the services it provided. And the superintendent pharmacist provided assurances that the appropriate insurance arrangements were in place for its prescribers. The pharmacy kept a record to show which pharmacist was the RP and when. And it kept a record of the private prescriptions it supplied to people on its patient medication record (PMR) system. The pharmacy didn't stock any controlled drugs. It didn't supply any unlicensed medicinal products. And it didn't make any emergency supplies of medicines. The company was registered with the Information Commissioner's Office. And its pharmacy had arrangements to make sure confidential information was stored and disposed of securely. The company's websites told people how it gathered, used and shared their personal information. Members of the pharmacy team were required to read and sign a confidentiality agreement. They completed training to help them safeguard vulnerable groups of people. And they knew what to do or who they would make aware if they had concerns about a person's safety.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team undergo training for the jobs they do. They're comfortable about giving feedback on how to improve the pharmacy and its services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The company employed several people. They included people working in its pharmacy team, clinical team, customer service team, leadership team and legal team. The pharmacy team consisted of the superintendent pharmacist, a dispensing assistant and two trainee dispensing assistants. The superintendent pharmacist was responsible for managing the pharmacy and its team. The superintendent pharmacist, the dispensing assistant and a trainee dispensing assistant were working at the time of the inspection. The pharmacy relied upon its team members, locum dispensers and locum pharmacists to cover absences. The superintendent pharmacist supervised and oversaw the supply of medicines by the pharmacy team. Members of the pharmacy team worked well together and supported each other. So, people's prescriptions were processed quickly, but safely. Members of the pharmacy team were required to undertake accredited training relevant to their roles after completing a probationary period. They were encouraged to ask questions and familiarise themselves with the products they dispensed. The superintendent pharmacist was required to keep their professional skills and knowledge up to date as part of their annual revalidation process. They could discuss clinical and governance issues during meetings with the clinical lead and the leadership team. They felt able to make professional decisions to ensure people were kept safe. And, for example, they recently intervened to prevent the inappropriate supply of a hormone replacement therapy. The company had a whistleblowing policy. It didn't set targets for its pharmacy team. And it didn't incentivise its services. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to the company obtaining an additional medical refrigerator.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. Its premises are clean and secure. And the websites it uses meet the GPhC's guidance.

Inspector's evidence

The registered pharmacy premises were set on the first floor of an office unit. They were air-conditioned, bright, secure, clean and tidy. And they were only accessible to authorised personnel. The pharmacy was spacious. It had a private area its team could use when needed. It had the workbench and storage space it needed for its current workload. And it could be easily reconfigured to create additional storage and workspace if needed. But improvements could be made to make the dispensing island more stable. The websites associated with the pharmacy provided the information they needed to in line with GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. And, for example, a person couldn't choose a prescription-only medicine before starting an online consultation. The websites also told people about the prescribers the company used. Members of the pharmacy team and a cleaner were responsible for keeping the premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services at a distance. But people can access these easily. The pharmacy uses a courier to deliver prescription medicines to people. And it keeps records showing the right medicine is delivered to the right person. The pharmacy generally has working practices that are safe and effective. But its team sometimes misses opportunities to make sure people get the most suitable treatment. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team mostly dispose of unwanted medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

People accessed the pharmacy and its services through the company's websites. And they could contact the pharmacy via the customer service team by telephone, email or a website chat function during business hours. The online prescribing service was provided to people aged 18 or over. People needed to complete an online questionnaire when requesting medication. And they were mainly asked closed questions. But if a person changed their answers in the questionnaire this wasn't flagged to the prescriber unless their answers differed from those they submitted during a previous consultation. 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.

People were required to set up an account when they started using the services. There were systems to identify people that had created multiple identities or accounts. And, when identified, these accounts were blacklisted so that any activity was flagged to the appropriate teams. All UK patient identity checks were carried out using a third-party identity checking service. This checked the person's identity and age using electoral roll and credit checks. If the checks failed, or the person wasn't 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 license, to confirm their identity and age. People provided their consent for the service, including authorising the pharmacy to dispense their medication, by agreeing to accept the terms of service during the ordering process. People were asked during the consultation to provide their consent for the company to contact their regular doctor. But this wasn't mandatory. And supplies, apart for treatments for chronic conditions such as asthma and diabetes, were often made without the company notifying the person's regular doctor of the treatment request. But when people didn't give their consent, they were provided with a letter they could share with their doctor detailing what they were prescribed and when, and by whom.

The team members responsible for making up people's prescriptions kept the dispensary and its workstations tidy. They referred to a copy of the electronic prescription when assembling people's medication. They initialled each dispensing label. Patient information leaflets were routinely supplied with dispensed medicines. And assembled prescriptions weren't dispatched until they were checked by the pharmacist who also initialled the dispensing label. The superintendent pharmacist described some recent clinical interventions where they prevented the inappropriate supplies of medicines including a weight-loss treatment and erectile dysfunction medication. The pharmacy used its PMR system to record the clinical interventions its team made. But the superintendent pharmacist conceded that clinical interventions weren't always recorded. The pharmacist could contact the prescriber to discuss the appropriateness of what had been prescribed. They also had access to the consultation

questionnaire and the patient's medication history as part of their clinical screening process. But they didn't routinely check these or the PMR. So, opportunities to make sure people were receiving the most appropriate treatment were sometimes missed. And, for example, repeated supplies of an antibiotic to the same person over a long time wasn't picked up by the prescribers or the pharmacist. The pharmacy didn't supply valproates. But members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. And they knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications.

People could provide a different delivery address to their personal address when ordering their medicines. But people's details and their delivery addresses were automatically copied to the pharmacy's PMR system from the prescribing system. And some people had more than one PMR record when they chose a different delivery address to the one they used before. The pharmacy used Royal Mail's tracked postal service to deliver medicines ordered through the company's website to people living in the UK. And it used a courier to deliver medicines overseas. The handover of assembled prescriptions to the delivery agent occurred at the pharmacy premises under the supervision of the RP. And an audit trail was kept for each order from the completed questionnaire through to its delivery. The pharmacy used discrete cardboard packaging to deliver these prescriptions. But improvements could be made to review the packaging it used to make sure it was more robust. The pharmacy used ice packs and a proprietary brand of insulated packaging when supplying products that needed to be refrigerated. It had assured itself that this delivery method maintained an appropriate temperature range during the transit of these products from the pharmacy to the delivery address. And it didn't supply medicines that required refrigeration overseas. The pharmacy had a process for dealing with orders returned to it. Its team quarantined any undelivered medicines when it received them. And in the event of the patient not arranging for their medication to be redelivered these medicines weren't reused but were disposed of.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. And it recorded when it had done these checks to reduce the chances of it giving people out-of-date medicines. The pharmacy's procedures didn't explain what the pharmacy team needed to do to make sure medicinal products were disposed of in a safe and effective manner. The pharmacy team made sure unwanted medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the team had put some hazardous waste medicines into the wrong type of bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And the superintendent pharmacist described the actions the pharmacy team took and demonstrated what records it kept when it received a drug alert.

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 it uses its equipment to make sure people's data is kept secure.

Inspector's evidence

The pharmacy had access to up-to-date reference sources. And these were relevant to the services it provided. The pharmacy team could contact the National Pharmacy Association for information and guidance. The pharmacy needed very little equipment for the services it provided. It had three medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of these refrigerators. 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. The pharmacy kept its equipment secure when it wasn't being used. And it had a shredder to dispose of the confidential waste it produced. The company had an in-house information technology support team. Its websites told people that security measures were in place to help protect their personal data and were 'https' secured.

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.