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: 27/06/2024

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 provided by doctors registered with the General Medical Council (GMC) and is regulated and inspected by the Care Quality Commission (CQC). The pharmacy mainly supplies medicines to people living in the United Kingdom (UK). And it dispenses medicines for pets too.

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 appropriately. It has written instructions to help its team members work safely. It keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy to help it do things better. People who work in the pharmacy log and review the mistakes they make to try to stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

The company that owned the pharmacy offered an online prescribing service. Its websites offered treatments for men's health, women's health, sexual health, general health and skin and nail conditions. 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 GMC registered doctor who was the company's clinical lead. The prescribers worked remotely or at the company's head office. The company had written risk assessments and policies for the services it provided. It had a corporate risk register too. And this included its prescribing service as well as its pharmacy operation. The company reviewed the risks associated with the types of medicines it supplied. It decided over two and a half years ago to stop supplying a medicine that could lower a person's blood pressure after attempts by people to obtain and use the medicine inappropriately. And it also stopped supplying 'off-label' weight-loss medicines following a review of a National Patient Safety Alerts that was issued last year.

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed at the beginning of the year. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and agreed to follow them. They 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. A team member explained that they couldn't assemble or dispatch prescriptions if a pharmacist wasn't present. The pharmacy had processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). The pharmacy team discussed, reviewed and recorded the mistakes it made to learn from them, and help stop the same sort of things happening again. And, for example, its team separated and highlighted the different pack sizes of an erectile dysfunction treatment following mistakes when the wrong pack size was selected.

The pharmacy displayed a notice that identified who the responsible pharmacist (RP) was. People have shared their views online about their experiences of using the company and its pharmacy. 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 other organisations including the GPhC. The company strengthened its processes to make sure people were counselled on how to take or use their prescribed treatment properly in response to a concern from someone 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 assurance that the prescribers had appropriate insurance arrangements in place too. The pharmacy didn't stock any controlled drugs. It didn't supply unlicensed medicinal products. And it didn't make emergency supplies of medicines. The pharmacy kept adequate records to show which pharmacist was the RP and when. And it kept an appropriate record of the private prescriptions and veterinary prescriptions it supplied on its patient medication record (PMR) system. The company was registered with the Information Commissioner's Office. Its websites told people how their personal information was gathered, used and shared by it and its team. And the pharmacy had arrangements to make sure confidential information was stored and disposed of securely. Members of the pharmacy team needed to read and sign a confidentiality agreement. They were required to complete training on data protection as well as safeguarding. And they knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

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 do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The company employed several people. And this included people working in the pharmacy team, the medical team, the customer service team, the leadership team and the legal team. The pharmacy team consisted of the superintendent pharmacist and four dispensing assistants. And the pharmacy depended upon its team members and locum pharmacists to cover any absences. The superintendent pharmacist was responsible for managing the pharmacy and its team. They supervised and oversaw the supply of medicines from the pharmacy. And they were the pharmacy's RP throughout the inspection and were supported by three dispensing assistants.

Members of the pharmacy team worked well together and helped each other. And they were up to date with their workload. Team members needed to complete mandatory training during their employment. They were also required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their manager when the pharmacy wasn't busy. They shared learning from the mistakes they made when they could. And they were encouraged to complete training while they were at work. 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 medical team 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 an erectile dysfunction treatment.

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 a new freezer and some more medical refrigerators.

Principle 3 - Premises ✔ Standards met

Summary findings

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

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 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.

The pharmacy was cleaned regularly. And the pharmacy team was responsible for keeping the premises tidy. The pharmacy team had access to appropriate handwashing facilities. And the building had a supply of hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has working practices that are generally safe and effective. And its team makes sure people have the information they need to take their medicines safely. The pharmacy sends prescription medicines to people's homes. And it keeps a log to show that it has delivered the right medicine to the right person. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. And they dispose of unwanted medicines properly too.

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 a treatment. But if a person changed their answers this was flagged to the prescriber. 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. But a patient could be contacted if further information was needed or when they needed to be signposted to another clinician or provider. And in certain circumstances, there could be a video or telephone consultation too.

People were required to set up an account when they started using the service. 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 regular doctor's details and give their consent for the company to contact them. This was mandatory before a treatment could be prescribed for asthma, contraception, an ear infection, hormone replacement, a urinary tract infection (UTI) or under certain circumstances for weight loss. It wasn't mandatory for people to provide consent for other treatments such as those for erectile dysfunction. And if a person didn't give their consent, they were provided with a letter they could share with their regular doctor detailing what they were prescribed and when, and by whom.

The pharmacist could contact the prescriber to discuss the appropriateness of what had been prescribed. They also had access to the consultation and the patient's medication history as part of their clinical screening process. The superintendent pharmacist provided an example of a weight-loss management record. And this included an up-to-date full-body photograph, the person's height, other relevant history and a summary of their weight over the treatment period. People were supported with their weight loss journey. They were counselled on how to use the prescribed medicine properly before and after a supply was made. And they were supported further by clinicians who specialised in nutrition and exercise. The superintendent pharmacist described a few recent clinical interventions where they prevented the inappropriate supplies of medicines including a UTI treatment for an elderly patient. And

the PMR system was routinely used to record the clinical interventions made by the pharmacy team.

The company didn't provide a veterinary prescribing service. But its pharmacy offered a veterinary prescription fulfilment service. People were required to post the original veterinary prescription to the pharmacy before a supply could be made. A sample of prescriptions seen during the inspection had been appropriately prescribed on each occasion by a veterinary surgeon for administration under the Cascade. The pharmacy had supplied a UK medicine licensed for human use as a licensed veterinary medicine didn't exist. And a suitable record was made in the PMR system by the pharmacy team for each supply.

The team members responsible for making up people's prescriptions kept the dispensary and its workstations tidy. They referred to the prescription or a copy 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 pharmacy used Royal Mail's tracked postal service to deliver medicines prescribed through the company's website to people living in the UK. And a courier was used to deliver medicines outside of the UK after a customs declaration was completed. 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 consultation 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 recipient's address. And it didn't supply medicines that required refrigeration overseas. The pharmacy had procedures for handling any unwanted medicines or orders that were returned to it. And these medicines weren't re-used. But were kept separate from the pharmacy's stock and were disposed of in an appropriate pharmaceutical waste bin.

The pharmacy didn't dispense valproates. But members of its team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people who were prescribed a valproate needed to be counselled on its contraindications. And they were aware of the rules on dispensing valproate-containing medicines in the manufacturer's original full pack.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines tidily on the shelves within their original manufacturer's packaging. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. And they marked products which were soon to expire. These things helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. The pharmacy had a process for dealing with the alerts and recalls about medicines issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And it had a process for notifying the MHRA if it had concerns about the medicines it supplied. A team member described the actions they took and what records they made when the pharmacy received an MHRA medicines recall.

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 its team makes sure the equipment it uses is suitable for what it's being used for.

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 several medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of each refrigerator on the days the pharmacy was open to make sure the temperature range was suitable. 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.