General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Healthcare and Aesthetic Pharmacy, 1 Guest Street, Leigh, Greater Manchester, WN7 2RP

Pharmacy reference: 9011857

Type of pharmacy: Internet / distance selling

Date of inspection: 05/01/2024

Pharmacy context

This pharmacy premises is closed to the public. It primarily provides dispensing services directly to prescribers and aesthetic practitioners. It is located in a small unit within an office building, in the town of Leigh, Greater Manchester. The pharmacy does not have an NHS contract, instead it specialises in supplying non-surgical cosmetic and aesthetic products, and consumables against private prescriptions generated by prescribers via its website www.refinepharma.com.

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

Members of the pharmacy team follow written procedures to help them work effectively. They record things that go wrong and discuss them to help identify learning. And they take action to reduce the chances of similar mistakes happening again. The pharmacist conducts audits and reviews and uses the findings to improve the pharmacy's services. The pharmacy team keeps the records required by law. And they understand how to keep people's information safe.

Inspector's evidence

The pharmacy provides services via its website. It supplied a range of medicines used in non-surgical cosmetic treatments against electronic prescriptions written by UK prescribers. Practitioners could also purchase non-prescription items directly from the website, such as dermal fillers, and injectable products. Anyone wishing to use the website was required to register an account and go through an 'on-boarding' process for approval. They were not able to place orders through the website until the account had been approved. If the account holder ordered a medicine that required a prescription, the website could be used to generate an electronic prescription and then a prescriber linked to their account could 'approve' it. Alternatively, the person could authorise the prescription themselves if they had prescriber rights. The orders would then be supplied by the pharmacy and sent via courier.

The on-boarding process to create accounts involved checking a person's identity against a passport photo or driving licence, their professional registration status, evidence of their training, and their certificate of insurance. Only a pharmacist or the operations manager were permitted to approve an account. The account checks identified which areas the practitioner was trained and insured to perform. The pharmacy's software was able to restrict particular medicines to individual accounts. This functionality was used to restrict what could be supplied to practitioners to those areas identified during the on-boarding process.

The pharmacy had a set of standard operating procedures (SOPs). Members of the pharmacy team had signed training sheets to say they had read and accepted the SOPs.

The pharmacy had completed risk assessments for the medicines it dispensed. The pharmacy restricted the maximum quantity which could be prescribed for some medicines to help ensure only the amount required for the intended treatment was supplied. The superintendent (SI) explained how the risks associated with the services had been considered. For example, the pharmacy had implemented controls, such as account restrictions, requesting certain declarations by the prescriber, and reducing the permitted time period to dispense a private prescription, to help manage the risks. However, risk assessments had not been documented, which meant the pharmacy was not able to show how risks had been identified or whether control measures were effective.

The pharmacy had completed an audit about the quality of the written directions on prescriptions. Over 150 prescriptions were included in this audit, and 66% were found to have inadequate or incomplete directions which had required interventions by the pharmacist to clarify the directions given. Following the audit, the pharmacy sent an email to all prescribers to remind them about the importance of the quality of the written directions. The pharmacy also updated its software to require a minimum number of characters for directions when prescriptions were issued. The pharmacy was due to complete a re-audit in a month's time to determine how effective these changes had been.

The pharmacy team had recently implemented a prescriber due diligence review of any prescribers who routinely used the pharmacy's services. This obtained information about the prescriber's professional registration, the prescriber's insurance against the medicines being supplied, whether the prescriber was operating out of a CQC-registered service and what the last inspection outcome was, any patient reviews on the internet, and details of any contact the pharmacy team had with the prescriber. The pharmacy would review the information to see whether any concerns had been identified which needed to be addressed. Approximately six reviews had been recorded since the process had been started.

Near miss incidents were recorded on a paper log. The pharmacist reviewed the records each month and discussed any learning points with members of the team in a monthly team meeting. The team had taken action to help prevent similar mistakes being repeated. For example, they had moved the similar sounding brands of botulinum toxins, Azzalure and Alluzience, away from each other in the fridge to help prevent picking errors.

Roles and responsibilities of the pharmacy team were described within SOPs. Team members were clear about their responsibilities and understood which tasks could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure, and this was displayed on the website. A current certificate of professional indemnity insurance was available. Records for the RP and private prescriptions appeared to be in order. The pharmacy did not stock any controlled drugs.

Information governance (IG) procedures had been implemented. And details about how the pharmacy used and protected people's information were displayed in a privacy policy on the website. A shredder was used to destroy any confidential information. Members of the team had recently completed GDPR training. Safeguarding procedures were included in the SOPs. The pharmacist had completed level 2 safeguarding training and the rest of the team had completed level 1 training. Members of the team said they would refer any initial concerns about people's safety to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload. Members of the pharmacy team complete training so that they understand the services they provide. And they can show how they use their professional judgement to help make sure people receive services safely.

Inspector's evidence

The pharmacy team included a pharmacist, a trainee pharmacy technician, and a dispenser. There was also a customer services team that did not work within the pharmacy. All members of the pharmacy team were appropriately trained. Staffing levels were maintained by a staggered holiday system.

The SI was a trained aesthetician. To help provide members of the team with a greater understanding of the products being supplied by the pharmacy, the SI had created a series of training videos. The videos explained about the different types of products the pharmacy supplied. There was a locum folder, containing the risk assessments, details about the medicines, and links to the training videos to help them to understand the products being supplied.

A folder contained records of any additional training which members of the team had completed. For example, they had recently completed a training pack about anaphylaxis. Training topics appeared relevant to the services provided and those completing the e-learning. Team members were allowed learning time to complete training. The trainee pharmacy technician said they would refer any medication queries to the pharmacist to answer.

Members of the team kept an electronic record of any interventions they made before supplying prescribed medicines, and any subsequent outcome. For example, the pharmacist had contacted the prescriber on one occasion where a new patient was prescribed a higher-than-expected strength of Wegovy. The prescriber confirmed the patient had been taking the medicine previously, but they had not had it dispensed by the pharmacy before.

The pharmacist held monthly team meetings to discuss ongoing work, share learning from mistakes, and any news updates. For example, they recently discussed the signs of potential fake weight loss medicines, in case the team received any telephone queries. Members of the team said they felt a good level of support from the pharmacist. Appraisals were conducted annually. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the pharmacist or SI. There were no targets in place relating to professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. And the pharmacy's website displays enough information for people to know who is providing the service.

Inspector's evidence

The pharmacy was located in a unit inside an office block. The premises were clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by a lockable door. The temperature was controlled using air conditioning units. Lighting was sufficient. Team members had access to a kitchenette and WC facilities.

The pharmacy website contained information about where the pharmacy was located, who owned it and the SI. It also explained how people could check the registration status of the pharmacy or SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works to professional standards to help it provide services safely and effectively. And the pharmacist completes checks to provide assurance that medicines are being appropriately prescribed. The pharmacy gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

Inspector's evidence

People who used the pharmacy's services accessed them through its website. The website had various help sections to provide support. It also included details about how to contact the pharmacy, the hours of opening, and how to contact team members when the pharmacy was closed.

Electronic prescriptions could be issued via the pharmacy website. Prescribers were required to provide information or various confirmations when they issued prescriptions to provide assurance to the pharmacy. For example, indicating the consultation had been completed face-to-face, details of the patient's allergies, a list of current medications, confirmation that any patient review or monitoring requirements had been completed, and that the medication was to be used by the named patient.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up.

The pharmacist completed a final accuracy check of dispensed items and completed a clinical check at the same time. This included reviewing the records on the computer for any past orders and any other medicines that had been supplied and checking the prescription date against the order date. There was also a check of the prescriber's professional registration against the relevant professional register to ensure there were no restrictions put in place against their practice. And the pharmacist also checked the date of birth on the prescription to ensure the intended person was over the age of 18 years.

Medicines were delivered using courier services. Electronic records of deliveries were retained. Any unsuccessful deliveries were returned to the pharmacy and the pharmacy team would contact the customer to check why the medicines could not be delivered. Medicines requiring refrigeration were sent using special packaging to keep the medicines within the required storage temperatures. The pharmacy had carried out testing to check the packaging worked effectively.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked at least once every three months. Records of date checking were available. Short-dated stock was highlighted using a colour-coded sticker which indicated the number of months remaining before it expired. There were clean medicines fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had remained within the required range for the last 3 months. Patient returned medication was disposed of in designated bins.

Drug alerts were received by email from the MHRA. Records were kept showing how the pharmacy responded when an alert had been received. In the event of an adverse reaction, the pharmacy was a member of the 'Aesthetics complication expert' group, which had written protocols to manage patient

safety incidents.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide.

Inspector's evidence

The team members had access to the internet for general information. All electrical equipment appeared to be in working order. Computers were password protected.

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.