

Registered pharmacy inspection report

Pharmacy Name: The Hormonist, 19 Westmoreland Road, London, NW9 9BW

Pharmacy reference: 9012198

Type of pharmacy: Internet / distance selling

Date of inspection: 22/08/2024

Pharmacy context

This is a private pharmacy, in northwest London and it is closed to the public. The pharmacy does not have an NHS contract. And it does not sell over-the-counter medicines. It only dispenses private prescriptions for hormone replacement from prescribers who are associated with an online company (<https://balancemyhormones.co.uk/>) regulated by the Care Quality Commission (CQC). And it delivers medicines direct to people's homes. The pharmacy is newly registered with the GPhC.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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 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 provides its services safely and effectively. It has suitable standard operating procedures in place which the team members follow to help identify and manage risks. It conducts regular risk assessments and audits to monitor how safe its services are and it protects people's private information appropriately. Records are mostly maintained in line with requirements. And team members understand how they can protect people's private information and safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The pharmacy team members discussed the mistakes they made to learn from them and agree actions to reduce the chances of them happening again. The superintendent pharmacist (SI) explained that medicines involved in incidents, were generally not similar in some way causing the mistake.

The pharmacy had systems in place to identify and manage the risks associated with its services. The SI described undertaking a series of risk assessments (RAs) regularly to identify and manage risks in the premises and included security, cleaning and the Control of substances hazardous to health (COSHH). And the SI monitored fire and electrical appliance safety. He also completed regular clinical audits, for instance for people who had medical conditions which required monitoring such with diabetes type 2 or were taking medicines which required therapeutic monitoring. The SI audited the patient database regularly and check their identity was uploaded and they were 18 years old or more and based in the UK. Pharmacy audits were conducted to provide assurances about delivery and prescribing services. The SI was aware of the updated guidance for dispensing and supplying valproates and topiramate.

The pharmacist received the prescription, input the prescription details onto their computer system and performed clinical check. The prescription was issued electronically and had a unique barcode with a signature that only the doctor could add. The prescription was not printed. If screening highlighted any issues the prescription was returned to the prescriber. Once approved, the prescription was dispensed at the pharmacy and checked by the SI. The SI added the batch numbers and expiry dates to the dispensing labels of any items supplied. In the event of an alert or recall, the people could be contacted. A full audit trail of any pharmacy team members who dispensed and checked prescriptions was maintained on their computer system. The SI explained that generally interactions between medicines prescribed for people were picked up at the first screen by the prescribing service at BMH. But if the pharmacy detected any interactions they were referred back to the surgery.

The SI prepared the standard operating procedures (SOPs) which had been reviewed recently. 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. The pharmacy had training records but they were not dated showing when training had been completed. The recent SOPs related to compounding, but they were not yet finalised. The pharmacy used couriers with a tracking function and temperature control for certain items it delivered to people. If items were missing on arrival the pharmacy asked the person to obtain a police report. The pharmacy complaints policy was set out on the website. People were provided with support emails and asked to complete a survey at intervals after commencing treatment.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. And maintained a record of which pharmacist was RP and when. The RP was present when the delivery items were dispatched with the couriers. The SI kept a record of interventions including on the patient's file on the treatment portal. The pharmacy made a record of consent to the treatment plan prior to dispensing a prescription. At the time of the inspection visit, the pharmacy did not obtain or supply any CDs requiring a record to be entered into a CD register. The private prescriptions were recorded in an electronic private prescription register and organised into monthly sections. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided.

The pharmacy was registered with the Information Commissioner's Office. And the pharmacy team was aware of general data protection regulation (GDPR). The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It collected people's personal information to be disposed of securely. The pharmacy had a safeguarding policy was available on the website. And the SI had completed level 3 safeguarding training. Safeguarding was an integral part of providing services such as weight management. The SI was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members work well together to manage their workload effectively. The pharmacy provides ongoing training to help keep the team's skills and knowledge up to date. They are comfortable about providing feedback and suggestions which the pharmacy has acted on to improve services.

Inspector's evidence

The pharmacy team comprised three full-time pharmacists and two full-time qualified dispensing assistants. Members of the pharmacy team were enrolled on or had completed accredited training relevant to their roles. They worked well together, following the pharmacy's procedures so prescriptions were processed safely. They completed the audit trail identifying who was involved at each stage of preparing each prescription.

The pharmacy conducted training audits to monitor training effectiveness and needs. It had an induction folder with information for new starters. The pharmacy supported team members with training via elearning resources to progress their roles and by allocating protected learning time at the end of the working day if needed. The team had undertaken training in safeguarding and general data protection regulation (GDPR).

The pharmacy held regular team meetings. Team members could provide feedback on improving how the pharmacy provided its services and had suggested how the pharmacy could improve and simplify how it supplied injectable products. They had appraisals at set intervals to monitor progress and devise a performance development plan in line with their roles.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide a secure and suitable environment for the provision of healthcare services. It has enough space to safely prepare and assemble prescriptions. And the pharmacy is kept appropriately clean.

Inspector's evidence

The registered pharmacy premises were spacious, clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy's premises included a staff area, a dispensary and a clean room which had been completed recently. The pharmacy did not have a consulting room as there was no face-to-face contact with people. But if a person wanted to speak to a member of the team, the pharmacy could facilitate a private conversation with a team member. The dispensary maximised the workspace and storage available. But worksurfaces in the dispensary were clean and tidy. The pharmacy was cleaned weekly.

The pharmacy had an online website (<https://www.thehormonist.com/>). The website displayed the GPhC internet voluntary logo, the SI details, the pharmacy's opening times, how people could complain, and the pharmacy's contact details. The pharmacy supplied the medicines from the address on the website. The website had no reference to any medicines but did explain it fulfilled private prescriptions. There was no option to choose a medicine, strength, or quantity.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally provides its services safely. It obtains its medicines from reputable suppliers. And it receives prescriptions from <https://balancemyhormones.co.uk/>. The pharmacy team checks the credentials of the prescribers and the BMH team confirm the identity of the people who access the pharmacy's services. The pharmacy makes sure medicines are safely delivered to the right person at the right address. And it knows what to do when it receives an alert or recall about one of the medicines it supplies.

Inspector's evidence

The pharmacy was located on the first floor, accessed by steps. It was registered as an internet pharmacy and not readily open to members of the public. It was a fulfilling pharmacy for prescriptions issued by BMH's prescribers based at Holburn Viaduct. And it dispensed private prescriptions for hormone replacement therapy and some medicines from prescriber's who were linked to the online website (<https://balancemyhormones.co.uk/>). The SI had compiled a list of the prescribers who issued the prescriptions. The SI said that he and the BMH team regularly checked the credentials of prescribers who issued prescriptions including on the General Medical Council's (GMC) register. There were no independent prescribers at BMH.

The pharmacy accessed the prescriptions and the patient's medical notes in addition to information on the pharmacy's own internal system. Team members cross-referenced different details on each of the databases to ensure the information they were using was correct. People's identity was verified by BMH via a 'selfie' photograph which was cross-referenced with a driving licence or passport.

The pharmacy received the private prescriptions from BMH. The prescribers had their own access to the portal and the prescription remained under the sole control of the prescriber. The pharmacy was alerted through its system workflow and after receiving it electronically, it was dispensed through the pharmacy's dispensing system. The supply was recorded on the electronic private prescription register. The SI had organised the private prescription register into monthly sections which were secure and encrypted. People were prescribed and supplied a range of sustainable medicines. Such as a topical preparation if the person was needle phobic and unable to self-inject. Other people were prescribed a medicine which had to be compounded by a pharmacy which had the capability to compound such medicines.

The BMH prescribers and treatment co-ordinators counselled people about their medicines, the dose, side effects and injection technique. People could speak to the pharmacy direct if advice was required. The BMH website displayed a film demonstrating injection technique for people to watch. Each person was given a sharps bin for safe sharps disposal at the beginning of their treatment journey. And they were signposted to local arrangements for sharps disposal.

When the private prescriptions had been received, they were labelled and dispensed by staff before being accuracy checked by the RP or SI. Baskets were available to keep prescriptions and medicines together during the dispensing process. There was an audit trail to help identify who had been involved in each stage of the dispensing process. BMH's prescribers prescribed other medicines such as for

weight loss and treating acne. This pharmacy supplied the medicines Wegovy and Mounjaro and lymecycline and Duac. BMH initiated treatment and monitored the people who were being treated. People had a mentor and were prescribed Wegovy and Mounjaro on a monthly basis. They were safeguarded and supported. The team were trained to look out for signs of body dysmorphia and other issues.

The pharmacy did not provide any additional services and it only dispensed medicines against private prescriptions as described above. The pharmacy did not stock, dispense or deliver Schedule 2 or 3 CDs. Once dispensed, the medicines were packed and sealed before being delivered. The pharmacy team confirmed the person's address was correct and that it matched the relevant details. The pharmacy used a courier service that had tracking facilities. Prescription items were enclosed in packaging which maintained items at the correct temperature. Cold chain items were dispatched in packaging which had been validated for maintaining medicines such as Wegovy, Mounjaro and Duac at between two and eight Celsius during delivery. There was a procedure for failed deliveries.

The pharmacy's stock was stored in an organised way and clearly identifiable. It was obtained from licensed wholesalers. The team members date-checked medicines for expiry regularly and kept records of when this had happened. They endorsed dispensing labels with batch number and expiry dates to identify affected medicines when responding to an alert or recall. The pharmacy did not stock any controlled drugs requiring safe custody but all medicines were stored securely and at the right temperature. Drug alerts were received by email, checked, and actioned appropriately. Records had been kept verifying this. And if people had received affected batches they were followed up.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment it needs to provide its services safely and protect people's private information.

Inspector's evidence

The pharmacy's equipment included online reference sources and a pharmacy fridge. The pharmacy team members monitored the maximum and minimum fridge temperatures. The pharmacy was in the process of establishing and equipping a clean room. Computer terminals were positioned in a manner that prevented unauthorised access.

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.