General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 59-61 Newland Avenue, HULL, North Humberside, HU5 3BG

Pharmacy reference: 1032114

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

This community pharmacy is on a busy road in a large suburb of Hull. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartmental compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. The pharmacy provides the flu vaccination service and a travel vaccination service. The pharmacy team provides free health checks such as blood pressure checks.

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	1.2	Good practice	The pharmacy team members complete detailed records about all the dispensing errors they make. This shows their learning. And the actions they take to prevent similar errors. The team completes comprehensive reviews of these records. So, it can ensure team members maintain the changes. And that the changes have the desired result of improving the safety and quality of services.
		1.4	Good practice	The pharmacy team asks for feedback from people using the pharmacy services. And it uses the feedback to improve the safety and quality of the pharmacy services provided.
		1.7	Good practice	The pharmacy has good arrangements to protect people's private information. Members of the pharmacy team identify and act appropriately following a data security breach.
2. Staff	Good practice	2.2	Good practice	The pharmacy provides all team members with opportunities to complete more training. The pharmacy provides training relevant to the team members roles. And the pharmacist sources additional training to further support the team's development. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. And the pharmacy recognises the team members achievements and it celebrates success.
		2.4	Good practice	The pharmacy promotes an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. And they openly discuss and regularly review their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills.
		2.5	Good practice	The pharmacy team members continually look for ways to improve. And they change how they work to help provide safer and more effective services.

Principle	Principle finding	Exception standard reference	Notable practice	Why
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team provides a range of services that support people's individual health needs. The pharmacy team members actively consider the possible barriers to people who access the pharmacy. And they take steps to overcome them. The pharmacy team reaches out to the community to promote people's health and wellbeing and the pharmacy services. The team proactively sources and promotes relevant literature to give to people using the pharmacy to help address people's associated health needs.
		4.2	Good practice	The pharmacy team completes risk assessments of the services provided. And it manages any risks by changing and implementing its processes. The team regularly takes opportunities when interacting with people to actively promote and offer health checks such as blood pressure checks. So, the team can help any people who may need healthcare advice or treatment.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has systems to identify and manage the risks associated with its services. And it keeps the records it needs to by law. It has good arrangements to protect people's private information. The pharmacy team asks for feedback from people using the pharmacy services. And it uses the feedback to improve the safety and quality of the pharmacy services provided. The pharmacy team members complete detailed records about all the dispensing errors they make. This shows their learning. And the actions they take to prevent similar errors. The team completes comprehensive reviews of these records. So, it can make sure the team members maintain the changes. And the changes have the desired result of improving the safety and quality of services. The team members have training, guidance and experience to respond well to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the near miss error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. And team members used codes to record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy completed an electronic report for dispensing errors. These were errors identified after the person had received their medicines. The team sent the report to head office. The pharmacy had trained all the team to complete the report. So, completion of the report was in a timely manner. The team also completed a root cause analysis (RCA) to identify why the error happened. All the team members were made aware of any dispensing incident, so everyone could learn from it. The pharmacist manager reviewed all the dispensing incident reports every six months. To ensure the team members were maintaining any changes to processes put in place after the dispensing incident. And to check that no similar errors had occurred. The pharmacist manager kept a record of these reviews. A recent incident involved a person receiving another person's medication. The team identified the cause as the person not hearing what the team member asked when confirming their address. The team decided in such circumstances to invite the person into the consultation room. So, the team member could raise their voice and be away from any noise distractions when asking these questions. Or to write the address details and ask the person to read and confirm they were correct. The team had recorded this as a breach of data protection regulations.

The pharmacist manager reviewed all near miss errors and dispensing incidents each month. This helped to spot patterns and make changes to processes. The pharmacist manager recorded the review and shared the results with the team members. So, they could discuss how to reduce errors and improve the safe dispensing of medicines. The pharmacist manager had recently highlighted to the team an increase with the number of near miss errors. The pharmacist informed the team that no

patterns with these errors had been found. The team members discussed and agreed there was often too much talking when team members were dispensing. And there was often a lack of focus due to distractions. The team discussed how to prevent these issues such as concentrating on dispensing. The pharmacist manager undertook a six-month review of the previous monthly reviews. This provided an opportunity to check that the team continued to follow any changes to procedure made after each review. And if any further changes or updates were needed. The pharmacist manager used an online platform to share the results from the review with the company so other teams could learn from them. This information formed part of the company patient safety newsletter which the pharmacist manager contributed to. A recent review listed the key learnings around the flu vaccination service and changes to the types of flu vaccines. The review also highlighted the changes the team made following an increase in the number of multi-compartmental compliance packs dispensed. To ensure it did not impact on the safe delivery of other services such as dispensing. The pharmacy had a patient safety notice board that provided key points for team members to refer to. Information included reminding the team of the process to follow when someone was hard of hearing. And a list of medicines that looked and sounded alike (LASA) that were at a higher risk of contributing to a selection error. For example, amlodipine and amitriptyline. The pharmacy had an eye-catching set of posters highlighting LASA medicines. These posters gave information to the team on what the medicine was for. And reminded the team to think about the person behind the medicine. So, team members were alerted to the effects supplying the wrong medicine could have on children or older people.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The pharmacy team members received positive comments from people about the pharmacy services they provided. The pharmacy team had introduced an extra step to the repeat prescription ordering service. This was after comments made by people that their prescriptions had not been ordered on time. A few people had commented about the availability of health information leaflets. So, the pharmacist manager moved information leaflets such as those provided by the British Heart Foundation to a prominent section of the pharmacy counter. This also acted as a prompt for the team to supply this information when handing over people's medicines.

The pharmacy kept electronic CD registers. The system prompted the team when a CD stock check was due. This helped to spot errors such as missed entries. The system also indicated if the person had collected their CD medicines. This helped the team spot CD prescriptions that may be close to the 28-day legal limit for supply. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). And recorded any GDPR breaches. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures in place. And the team had access to a large amount of safeguarding information including contact numbers for local safeguarding teams. The pharmacist and the pharmacy technicians had completed level 2 training in 2018 and 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2016 and 2018. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides training relevant to the team members roles. And the pharmacist sources additional training to further support the team's development. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their career. And the pharmacy recognises the team members achievements and celebrates success. The pharmacy promotes an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. And they openly discuss and regularly review their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacy team members continually look for ways to improve. And they change how they work to help provide safer and more effective services.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pharmacy pre-registration student, two full-time registered pharmacy technicians, one who was also an accuracy checking technician, two part-time pharmacy technicians, two full-time dispensers, one who was the pharmacy supervisor, a part-time dispenser and a delivery driver. The pharmacist manager provided support to pharmacy teams in other Day Lewis pharmacies.

The pharmacist manager was the tutor for the pharmacy pre-registration student. The two had discussed the year ahead based on the structured programme and personal objectives of the student. This included focusing on a clinical topic each month such as cardio-vascular disease or mental health. The pharmacist took a photocopy of a prescription containing medicines for the medical condition the pre-registration student was focusing on. The pharmacist removed the person's details from the prescription before attaching a sheet of questions for the student to answer. The questions included what the medicine was used to treat, what were the main side effects from the medicine and what, if any, tests did the person need when taking the medicine. The pharmacist manager involved the pharmacy pre-registration student with the review of dispensing errors as part of their training programme.

The pharmacist manager had arranged for several patient group directions (PGDs) to be available to support a range of pharmacy services. The PGDs gave legal authority for the pharmacist to provide the pharmacy services. This work led to the pharmacist manager being invited on to a company PGD group to support the development and roll out of PGDs to other Day Lewis pharmacies. The pharmacist manager helped produce the patient safety section of the company newsletter.

The pharmacy team completed extra training through monthly online learning modules provided by an external company. The pharmacist manager had registered the pharmacy to receive these modules to support the internal training provided by the company. Recent training modules included sepsis and cervical cancer. The pharmacist manager had found the sepsis training useful for all the team. As this was usually limited to pharmacy professionals via the CPPE. The team members had protected time to complete the training. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had used the review to ask for more opportunities to work on the pharmacy counter. So, they could maintain their

knowledge and skills in the sales of over-the-counter products. The pharmacy promoted the success achieved by team members. The team had received several awards from the company and external organisations. This included recognition of the work the team did to promote and be actively involved with the healthy living pharmacy agenda. The team had won the Community Pharmacy Humber award in 2017 based on two nominations, one from the pharmacist manager reflecting the services the team provided, the other from a person using the pharmacy. The pharmacy displayed individual training achievements such as a team member who had recently registered as a pharmacy technician. This team member contributed an article to a training newsletter about their progression from pharmacy apprentice to a recently qualified pharmacy technician.

The pharmacy held weekly team meetings. The pharmacy recorded who in the team attended and the team members signed to say they had attended. The details of the meeting were shared with the team members who were not present. The pharmacy recorded details of the matters discussed such as patterns from near miss errors. The pharmacist manager used a recent team meeting to highlight a near miss error when an antibiotic suspension had been dispensed in the powder format without being correctly prepared. The team had discussed the new pharmacy contract and the implications for the team. One outcome from the discussions was the development and implementation of a team rota of key tasks to be completed each day. The pharmacy had a whistleblowing procedure informing the team members of the steps to take if they had a concern. The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. The pharmacist manager offered the services when they would benefit people. And encouraged the team to promote services such as the blood pressure checks.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And it used different coloured cloths to wipe up spills from the methadone bottles from other liquid spills. The consultation room contained a sink and alcohol gel for hand cleansing. The pharmacy displayed notices next to the sink describing effective hand washing techniques. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had two large, sound proof consultation rooms. The team used both rooms for private conversations with people. And when offering pharmacy services such as supervised methadone and the flu vaccinations. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides a range of services that support individual people's health needs. The pharmacy team members actively consider the possible barriers to people who access the pharmacy. And they take steps to overcome them. The pharmacy team reaches out to the community to promote people's health and wellbeing and the pharmacy services. The team proactively sources and promotes relevant literature to give to people using the pharmacy to help address people's associated health needs. The pharmacy team completes risk assessments of the services provided. And it manages any risks by changing and implementing new processes. The team regularly takes opportunities when interacting with people to promote and offer health checks such as blood pressure checks. So, the team can help any people who may need healthcare advice or treatment. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines well.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The pharmacy kept a range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy supervisor was the healthy living champion. And used a large section of the retail area to promote healthy living advice. The current focus included the stop smoking campaign. This was linked with the smoking cessation service provided by a local organisation who attended the pharmacy and used the consultation room to provide this service. The team also used a section of the retail area to provide people with information on local support groups. The information included leaflets the team obtained to pass on to people or their carers when they were diagnosed with medical conditions such as dementia.

The service providing blood pressure (BP) checks was popular. The team focused on people who were not already diagnosed with high blood pressure and prescribed medicines. As they would be monitored. The team placed a sticker on the prescription to alert the pharmacist to have a conversation with the person about BP checks. The team used opportunities such as people attending for the flu vaccination service to offer the blood pressure checks. The team asked people to sit for ten minutes before their blood pressure was taken. So, it was more likely an accurate reading could be achieved. The blood pressure check included a test for atrial fibrillation. If the blood pressure reading was high the team gave the person a BP machine to use at home for them to take regular readings. The person presented the readings to the pharmacist who checked the results and took appropriate action such as referring the person to their GP. And giving the person healthy living advice. The pharmacy had a large amount of information provided by the British Heart Foundation to support this service.

The team had attended local events to promote and offer the BP checks. And other health checks such as carbon monoxide readings for people who smoked. So, the team could discuss smoking cessation options. The team had liaised with Hull University to raise awareness of sexual health matters with the students. The team members regularly accessed the Hull Making Every Contact Count (MECC) website. So, they could signpost people to providers of health advice and support, such as mental wellbeing. And provide up-to-date contact information for these providers. The team members kept records of when they had signposted people and any healthy living advice given. The computer on the pharmacy counter had access to the electronic patient record (PMR) which the team used to inform people or their carers

if the prescription had arrived and check what medication they were prescribed if they were requesting OTC products. The pharmacy had a large plastic magnifying glass on the pharmacy counter. The team offered this to people to use who needed help reading small print such as completing the back of the prescription. The pharmacy also had pens made with a grip to help people who had difficulty holding typical pens. The team kept information near the pharmacy counter for reference to when selling over-the-counter (OTC) products. For example, a list of cough mixtures that did not contain alcohol.

The pharmacist manager had sourced several patient group directions (PGDs). The PGDs gave the pharmacist the legal authority to provide services such as the administration of the flu vaccine and the travel service. The pharmacist manager completed a risk review before new pharmacy services were planned. And did regular follow-up reviews of the risks to ensure nothing had changed. The pharmacist manager developed a template to capture the details from the review and shared the results of the review with the pharmacy team. The pharmacist manager had recently completed a risk review of the new community pharmacy consultation service to identify possible risks with supplying people with medicines through this service. The pharmacist manager completed risk assessments for the flu vaccination and travel services and recorded the results. The risk reviews included checks on the suitability of the room where the pharmacy provided the services and the equipment used. The pharmacist manager had liaised with a nurse who provided travel vaccinations when completing the risk assessment for this service. The flu vaccination service was popular. People commented on the convenience of the service. And the time the pharmacist spent with them, which provided an opportunity for them to talk about other health matters. The team offered people a walk-in service and made appointments. The travel service was popular. The pharmacist made an initial assessment of where the person was travelling to and the vaccines or preventative medication required. And provided this to the person who made the decision to receive the vaccines or not. The pharmacist provided people with a vaccination plan which gave details of the vaccines injected and when additional vaccines were due. The pharmacist recorded on to the PMR the details of the vaccines given to the person and any advice given such as how to prevent sickness when abroad. The pharmacist recorded when the person had declined the vaccine. The pharmacy had in-date adrenaline injections in case a person had an anaphylactic reaction to a vaccine.

The pharmacy provided multi-compartmental compliance packs to help around 40 people take their medicines. People received monthly or weekly supplies depending on their needs. Two of the team managed the service. And got support from others in the team. The pharmacy had seen an increase in the number of packs. To manage the workload the team divided the preparation of the packs across the month. And worked one week ahead of when the next supply was due. The team ordered the prescriptions in time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a room off the main dispensary to dispense the medication. This was away from the distractions of the retail area and main dispensary. The team members picked the medicine stock before dispensing and had it checked by the pharmacist. So, any picking errors could be spotted before the team removed the medicine from the container. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets.

The pharmacy supplied methadone as supervised and unsupervised doses. The team prepared the methadone doses using a Methasoft electronic pump. The pump was linked to a laptop that the team updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy the team selected the person from the laptop. And sent the dose to the pump to pour in to a cup for the person to take. The team asked the person to confirm their date of birth, their address and the dose they were expecting before supplying the methadone. This acted as a check that the team had

selected the correct person. A notice on the door into the consultation room where the doses were given reminded the team to ask these questions. The team separated prescriptions for sugar free methadone from ones for the original version. And separated prescriptions with doses supplied that day from those awaiting supply. The pharmacy had a notice produced by the National Pharmacy Association (NPA) informing the team of the risks associated with the use of alcohol and methadone. The notice included frequently asked questions about this matter. So, the team could discuss this with people when the opportunity arose. The team used one of the consultation rooms when providing people with their methadone doses. The room had a range of information for people using the room. The information included how to safely inject drugs and contact details of a helpline to support people who were homeless.

The team members provided a repeat prescription ordering service. The team members asked the person what medicines they wanted for the next supply. And gave the person a slip informing them of the date when their next supply was due to collect. The slip had a note asking the person to contact the pharmacy when any changes were made to their medicines between collecting their medicines and the next supply. The slip also reminded people to only order the medicines they needed. To help reduce the amount of medicines returned unused to the pharmacy. The team marked the prescription to show that the person had been asked what medicines they needed and had been given the next due date. So, everyone knew this had been done or could act if there was no marking to suggest the person had been asked about their next prescription. The team usually ordered the prescriptions a week before supply and used an electronic system as an audit trail to track the requests. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The team highlighted to people when medication reviews or blood tests were due. The pharmacy was part of an NHS service designed to reduce the volume of unused medicines returned to the pharmacy for destruction. When a person told the team they did not want a medicine the team recorded this and informed the person's GP using the NHS communication system, PharmOutcomes. The team kept detailed notes on the person's electronic record (PMR) of any communications with other healthcare professionals such as their GP. The pharmacist manager implemented this following concerns raised by locum pharmacists that they did not know if a query had been raised with the relevant healthcare professional. And so, the locum pharmacist had found they were asking questions that had already been dealt with. The pharmacist manager recorded all prescribing incidents and shared this with the team at the company head office. The pharmacy was the most prolific reporter of prescribing incidents in the company. The pharmacist undertook a six-month review of the prescribing incidents to spot patterns to alert the pharmacy team to. And to share with pharmacist colleagues.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The team attached stickers to prescription bags for products such as warfarin to prompt the team member handing the medicine over to ask for information from the person. For example, their latest blood test results. And the team recorded this information when it was given. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy displayed a PPP poster to remind the team of the criteria and it had the PPP pack to provide people with information when required. The pharmacist manager used team meetings to highlight when team members were not following the procedure for prescriptions with high-risk medicines.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed

the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. This included separate boxes holding prescriptions that included CDs not requiring storage in a CD cabinet. So, the team was prompted to check the prescription date when handing over the medicines. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a stamp used as an audit trail of who had clinically checked, and accuracy checked the medication. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The team separated medicine stock for owings when it arrived from the wholesaler. So, the dispensing of these items was given priority. The pharmacy kept a record of the delivery of medicines to people. And the delivery driver obtained a signature from the person receiving the medication. The pharmacy had a cool box to store medicines removed from the fridge during delivery.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 23 September 2019. The team used coloured dots to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy had equipment to meet the requirements of the Falsified Medicines Directive (FMD). But the team was waiting for the roll out of the training and use of the equipment. No date had been given. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record including details of the checks the team had completed on who had been prescribed the affected product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it monitors its equipment to ensure it remains safe to use. The pharmacy has provisions in place to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy used equipment from reputable sources such as a Mircolife BP monitor and Methasoft. And it regularly checked the equipment to ensure it was safe to use.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.