General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Alpha Pharmacy, 193 Edgware Road, The Hyde, LONDON, NW9 6LP

Pharmacy reference: 1040656

Type of pharmacy: Community

Date of inspection: 03/07/2019

Pharmacy context

This is a community pharmacy located amongst a busy main road and parade of shops in London. The pharmacy dispenses NHS and private prescriptions. It provides Medicines Use Reviews (MURs) and the New Medicines Service (NMS). And it supplies some people with their medicines inside multi-compartment compliance aids, if they find it difficult to take their medicines on time.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy is not identifying and managing several risks associated with its services as failed under the relevant principles. The pharmacy's standard operating procedures (SOPs) do not reflect current practice and staff are not working in line with these. There is no evidence that the team has read the SOPs. Staff are not trained to safeguard vulnerable people and they are posting medicines through people's doors without making relevant safety checks
		1.2	Standard not met	There is not enough assurance that the pharmacy has a robust process in place to manage and learn from dispensing incidents. Staff are not routinely recording near misses, their dispensing incidents are not recorded in a way where details can be easily retrieved, full details are not documented and there is limited evidence of remedial activity or learning occurring in response
		1.3	Standard not met	Pharmacy services are not provided by staff with clearly defined roles and clear lines of accountability. There is evidence of errors but there are no audit trails in place to identify who was involved, the roles and responsibilities of staff are not clearly documented, the pharmacy's SOPs do not make it clear where responsibility lies for different pharmacy activities. The pharmacy is not routinely maintaining audit trails so that it can always identify who was responsible for any professional activities
		1.4	Standard not met	There are limited systems in place to deal with complaints or feedback. The pharmacy does not provide people with information about how they can complain and there is no documented complaints procedure in place
		1.6	Standard not met	The pharmacy is not maintaining all of its records in accordance with the law. This includes the RP record and records for private prescriptions. Staff have not kept appropriate records of Controlled Drugs brought back by the public for disposal. At the point of

Principle	Principle finding	Exception standard reference	Notable practice	Why
				inspection, the team was unable to provide records for unlicensed medicines or all of the private prescriptions dispensed in the pharmacy
		1.7	Standard not met	The pharmacy is not routinely safeguarding people's confidential information and there is no evidence that governance arrangements are in place for this. There is confidential information left in an unlocked consultation room, the team does not remove confidential information before placing medicines requiring disposal within waste bins, there are no specific documented details to support the management of confidential information, staff have not signed confidentiality agreements and this includes people working at the pharmacy who are not employed by them, the pharmacy does not inform people about how their private information is maintained, staff are not trained on recent developments in the law and people's sensitive information can be seen from the way signatures are obtained during the delivery service
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to safely and effectively provide pharmacy services
		2.2	Standard not met	There is not enough assurance that staff have the appropriate qualifications for their role(s) or are enrolled onto accredited training in line with the GPhC's requirements. This includes the relative of the owner who is not employed by the pharmacy but sometimes works for them and sells medicines
3. Premises	Standards not all met	3.1	Standard not met	Pharmacy services are not provided from an environment that is appropriate for the provision of healthcare services. Most of the pharmacy is extremely cluttered, this includes the consultation room, there are several unnecessary items present in the back area, dispensed medicines stored here in plastic bags are not sealed appropriately to prevent contamination from spiders and staff are not ensuring that the fire exit is kept clear at all

Principle	Principle finding	Exception standard reference	Notable practice	Why
				times in line with Health and Safety legislation
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Pharmacy services are not managed or delivered safely and effectively. The team is not using dispensing audit trails, prescriptions are not used during the dispensing process or when dispensed medicines are handed-out, staff are routinely claiming payment for medicines before they have been collected by people, owing slips are not routinely used, compliance aids are sometimes left unsealed overnight, descriptions of medicines and Patient Information Leaflets are not routinely provided when people are supplied with these, and people prescribed higher-risk medicines are not routinely identified, counselled or relevant checks made
		4.3	Standard not met	There is insufficient assurance that stock is stored and managed appropriately. The pharmacy stores some of its medicines in a disorganised way, there are mixed batches, loose blisters, access to some medicines that need to be kept more secure, evidence that patient returned medicines are stored close to dispensary stock, there are no means available to store patient returned hazardous and cytotoxic medicines appropriately and verifiable processes to routinely identify as well as remove date-expired medicines are lacking
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not effectively manage risks associated with its services. It has written instructions to help with this. But members of the pharmacy team are unable to show that they have read them. This could mean that they are unclear on the pharmacy's current processes. Pharmacy team members deal with their mistakes responsibly. But, they are not always recording or formally reviewing them. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. Team members know to protect people's private information, but they have not been trained on recent updates in the law. And, not all the pharmacy's team members understand how to protect the welfare of vulnerable people. So, they may not know how to respond to concerns appropriately. The pharmacy is not maintaining all of its records, in accordance with the law. This means that team members may not have all the information they need if problems or queries arise.

Inspector's evidence

Apart from the retail space, all other areas of the pharmacy were extremely cluttered (see Principle 3), this included the area where the responsible pharmacist (RP) conducted the final accuracy-check. The pharmacy's paperwork and the way some stock was held was disorganised. The inspection took place after mid-day and only the superintendent pharmacist was initially present (see Principle 2).

There were only about 10 to 12 near misses seen recorded, and they were from 2018 up until January 2019. The RP admitted that these had not been documented after this period. The owner explained that the RP held a discussion with staff every time a near miss occurred, this was to inform them and to raise their awareness about the situation. The RP described noticing that errors occurred at the end of the day, near misses with new medicines were seen, they were already separated, and according to her, no real patterns had occurred. The review process was informal and there were no details documented to verify this process.

There was no information on display about the pharmacy's complaints procedure and the pharmacy did not have a documented complaints procedure. The RP handled incidents, her process involved checking details, rectifying the situation, apologising and recording the details. The owner described placing details about errors on the person's record, but could not recall enough information to retrieve the record and the last error was seen recorded in the near miss register. This record was different from the other records as a person's bag label was used to record the information, but this did not highlight that a dispensing error had occurred. Details about the root cause analysis had also not been recorded or which staff were involved.

Some documented standard operating procedures (SOPs) were present to support the services provided. However, several of the details did not match the pharmacy's current practice (see Principle 4). Examples included the way dispensed prescriptions were to be stored, separating hazardous and cytotoxic medicines from returned medicines that required disposal. And also the process for entering relevant details about Controlled Drugs returned by the public for disposal, before placing them in the CD cabinet (see below). There were also some SOPs missing, including guidance on the management of people prescribed higher risk medicines and no information about the way Advanced Services were conducted.

The SOPs were last reviewed in 2018, the team's roles and responsibilities were not defined within

them and although the RP explained that staff had read the SOPs that were relevant to them, there was no indication that this had occurred. In general, the owner understood his role and responsibilities. He knew when to refer to the RP and he generally, knew which activities were permissible in the absence of the RP. However, he did state that he wouldn't be able to sell Strepsil's in the absence of the pharmacist. An incorrect RP notice was on display. The RP was instructed to change this at the start of the inspection and to ensure they complied with legal requirements going forward.

The RP was trained to level two via the Centre for Pharmacy Postgraduate Education (CPPE) to safeguard vulnerable people. After some prompting, the owner could identify groups of vulnerable people that could require safeguarding, he informed the RP in the event of a concern and described knowing this information as it was common sense. The inspector was told, and it was clear that staff had not been trained on this. An SOP to safeguard vulnerable people was present, this included local contact details for the safeguarding agencies. However, other than the RP, the owner was not aware of these, that an agency existed or where to locate the details. There was no chaperone policy seen.

The team segregated confidential waste which was removed using an authorised carrier, waste consignment notes were seen to verify this. Dispensed prescriptions awaiting collection were stored in a location that prevented sensitive information being visible from the retail area. There was confidential material left within areas that faced the public (see Principle 3). Staff were not trained on the EU General Data Protection Regulation (GDPR) and had not signed confidentiality clauses. There was no information on display to inform people about how their privacy was maintained and no Information Governance policy to provide guidance to the team.

Emergency supplies were seen to be recorded in line with statutory requirements and a sample of registers checked for Controlled Drugs (CDs) were in general, maintained in line with the Regulations. Occasional details in headers were missing and there were incomplete addresses for wholesalers from whom CDs were received. Balances for CDs were checked, and details seen documented every few months. On randomly selecting CDs held in the cabinet (Zomorph, Palexia), their quantities matched the balance recorded in corresponding registers.

The team checked the minimum and maximum temperature of the fridge to ensure medicines were appropriately stored here. Daily records were kept verifying this, although there were some omissions seen in the recent month. A book was in place to record details about the receipt and destruction of Controlled Drugs that had been returned by the public for disposal. However, this was blank, returned CDs were present in the cabinet, this was discussed at the time. The owner described a previous pharmacist, destroying CDs in the last year and there were no records available to demonstrate this.

The owner explained that some of the pharmacy's paperwork (such as invoices) were stored in his garage, some were with his accountant and the remainder were seen stored in a disorganised way, in one corner of the pharmacy. Records could therefore, not be easily located. This included all the private prescriptions dispensed in the last two years, as only a handful were found, and no records of unlicensed medicines were available for inspection.

There were several and sustained omissions seen in the RP record where pharmacists had not recorded the time that their responsibility started or finished, records were seen crossed out with no appropriate amendments made to explain the situation, some entries were not entered in chronological order and overwritten entries were seen. There was only one record for a private prescription documented (from May 2019) in the pharmacy's register that was kept for this purpose.

From the pharmacy's system and the handful of private prescriptions located, the pharmacy had routinely dispensed private prescriptions in the past two years. Occasional private prescriptions seen

dispensed were missing the date, the pharmacy had dispensed private outpatient prescriptions from hospitals, when there were clear instructions on them that they were to be dispensed in the hospital's outpatient pharmacy and one private prescription, dispensed for zopiclone was photocopied and it was not the original. There was no evidence that relevant checks were made before this was supplied.

The last professional indemnity insurance certificate seen for the pharmacy was from the National Pharmacy Association (NPA) and was due for renewal after the 4 December 2016. After discussing the situation with the owner, he provided documented details about the pharmacy's employer liability, public liability and several other areas that were insured (such as buildings and contents). This clearly stated that this insurance did not cover them for dispensing errors or dispensing activity.

The owner was asked to provide evidence/confirmation that the pharmacy held professional indemnity insurance at the time of inspection and from 2016, this was received and demonstrated that the pharmacy was continually insured for its professional services through the NPA.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough staff to manage its workload safely. Some members of the team appear to be carrying out tasks that they are not trained for or qualified in. This increases the risk of things going wrong. It can affect how well the pharmacy cares for people and the advice that it gives. And, once team members have completed basic training, the pharmacy does not provide them with many resources or training materials to help keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy dispensed 5,000 prescription items every month with around 50 people receiving their medicines inside Monitored Dosage Systems (MDS). The superintendent pharmacist (SI) was the only person present at the pharmacy when the inspection first started, the inspector was told that she had spent most of the day alone as the owner came in at 11am and was not present when the inspector arrived after 1pm. The pharmacy was clearly short-staffed.

The owner arrived shortly afterwards after he was telephoned by the SI. He worked most days at the pharmacy, anywhere between 30-35 hours, but his set hours were varied, he explained that he completed training for the medicines counter assistant (MCA) when he was 16, his tasks involved selling medicines, putting stock away, dispensing, delivering medicines, this role was shared with his uncle and he was also responsible for buying medicines. He stated that he was enrolled onto a dispensing assistant training course with the NPA at the outset of the inspection. At the end of the inspection, the owner stated that he had not finished the dispenser training previously and had re-enrolled recently, the pharmacy was asked to provide evidence of this and no confirmation was received following the inspection.

The uncle who delivered medicines was not employed by the pharmacy, according to the owner, he had worked in another pharmacy previously, the inspector was told that he had completed MCA training in the past and sometimes worked at the pharmacy/sold medicines. The pharmacy was asked to provide evidence of his training and no confirmation was received following the inspection.

There was one other member of staff, who was trained as an MCA and described as enrolled onto accredited training for the dispensing assistant's course with the NPA. This person's certificate of qualification for the MCA course was seen. However, the pharmacy was asked to provide evidence of their enrolment onto an accredited dispensing assistant's course and no confirmation was received following the inspection.

All staff worked part-time. Both the owner and SI acknowledged that they did not have enough staff, they were currently advertising to recruit a full-time MCA and dispensing assistant, they had used pharmacy students in the past and described difficulty in obtaining and retaining staff. There was not enough staff at the point of inspection to safely manage the pharmacy's workload. Pharmacists were left alone for periods of time as the remaining staff are part-time, or work ad-hoc. The owner works flexible hours and the pharmacy is not up-to-date with most of its obligations as seen from the other Principles.

The owner asked people some questions before over-the-counter (OTC) medicines were sold. This included asking people if they had taken anything before, if they were taking anything currently, how

old the person was, about medical conditions and symptoms, these details were then brought to the attention of the RP. Some knowledge of OTC medicines was demonstrated, the owner was frequently observed involving the RP in most transactions and explained that he ran everything past her. However, he mentioned not more than 100 paracetamol tablets could be sold in one transaction, he thought that products for use on the feet could be sold to people with diabetes but stated that he would check with the RP first. Both situations were discussed during the inspection.

There were few resources available to assist staff with training needs. The SI passed them magazines to read, and instructed them on clinical matters, the owner described instructing them about buying medicines or commercial topics. The MCA/trainee dispensing assistant was relatively new to the pharmacy and no appraisals had yet occurred. Staff progress was being monitored informally.There were no formal targets set to complete services, the SI explained that she had asked pharmacists to increase the amount of services they provided where possible.

Principle 3 - Premises **Standards not all met**

Summary findings

In general, the pharmacy's premises are appropriate for the effective delivery of healthcare services. But, pharmacy team members are not maintaining the premises in a safe manner. They are keeping the consultation room in a way that is not appropriate for the professional use of that space. And, the team is storing prescription-only medicines in there. This increases the chance of people gaining unauthorised access to them. The pharmacy stores excess clutter in some places that by law, must be kept clear. Its workspaces are extremely untidy. This increases the risk of mistakes happening. And the pharmacy stores some assembled prescriptions directly on the floor. This could damage medicines and may be a trip hazard.

Inspector's evidence

The premises consisted of a spacious sized retail area and smaller dispensary. This extended into a back area, where there was an office/staff kitchenette area, WC facilities to one side as well as a main area where medicines were stored, assembled prescriptions were in baskets to one side (without prescriptions), as well as dispensed prescriptions awaiting collection.

Every workspace in the dispensary was taken up with baskets of prescriptions awaiting assembly, paperwork, general clutter or stock. The main back section was also disorganised and cluttered, there were random items seen in here, such as power tools, cables, a door that was taken off its hinges, totes, a vacuum cleaner, shelving and general clutter. Access to the fire exit was also blocked with some of these items. Dispensed prescriptions were stored in poorly sealed carrier bags, inside cardboard boxes and spiders were seen crawling in and amongst them in this location.

Some dispensed medicines were seen stored directly on the floor in the dispensary. There were several cardboard boxes full of stock in the retail space. These were stored to one side appropriately. The owner explained that he had just received the pharmacy’s monthly order. A signposted consultation room was available to provide services and private conversations. The space was small but of an adequate size for this purpose. However, the room was kept unlocked, the door was open, the room was cluttered with various items and boxes, this included bulky dispensed prescription-only medicines (POMs) that were awaiting delivery. The owner was instructed to keep this door locked or remove access to POMs/confidential information, the door was subsequently locked, but the key was left in the lock until the inspector removed this, at the end of the inspection.

The pharmacy was suitably lit and appropriately ventilated. It was generally appropriately presented although the carpet required vacuuming and some ceiling tiles were stained. Pharmacy (P) medicines were stored behind the front counter and there was gated access into this area. Staff were always within the vicinity, which helped to prevent the self-selection of these medicines.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy team is helpful and generally ensures that people with different needs can easily access the pharmacy's services. But the pharmacy does not always provide its services in a safe and effective way. The pharmacy makes some checks to ensure that medicines are not supplied beyond their expiry date. But, it has no up-to-date written details to confirm this. And, it doesn't store some of its medicines appropriately. Pharmacy team members are not preparing medicines in a safe and effective way. This also applies to the way in which they store their dispensed prescriptions and from the way they provide some of their services. The pharmacy delivers prescription medicines to people's homes. But its records for this are disorganised and limited. This means that team members may not have all the information they need in the event of future queries. And, people can see other people's private information when they sign to receive their medicines. The pharmacy's team members sometimes fill compliance aids then leave them unsealed overnight while they wait for them to be checked. This means that the medicines are not very well protected and could be damaged or contaminated. It may also increase the risk of mistakes happening.

Inspector's evidence

The pharmacy's front entrance was accessed via a ramp with an automatic door. This, along with the wide aisles inside the premises and clear, open space meant that people needing wheelchair access could easily use the pharmacy's services. There were two seats available for people to wait for their prescriptions if needed. The owner was trained to use sign language and had used this to assist people who were deaf. The team was multilingual, they could speak Gujarati, Hindi, Urdu, Kachhi, Arabic, French, Somali and Swahili, staff used simpler language to assist people who first language was not English and physically assisted people who were visually impaired.

The pharmacy team used baskets to hold medicines once they were dispensed. This helped to prevent any inadvertent transfer. However, the RP and staff were not using dispensing audit trails. On selecting randomly dispensed medicines and opening the bags, there were no details marked on generated labels to indicate who had dispensed/assembled or accuracy-checked medicines.

The RP was observed using generated labels to check for stock. There were no prescriptions seen with baskets holding dispensed medicines or attached to dispensed prescriptions and very, very few prescriptions were seen within the alphabetical retrieval system. This system contained empty plastic wallets with the bag label attached, for the person. The owner was observed handing out dispensed medicines using this empty wallet. He explained that the bulk of the pharmacy's workload was from electronic prescriptions, and the tokens were not printed. This meant that prescriptions were not being used to accuracy-check relevant details on hand-out. The RP stated that she looked at the electronic prescription before medicines were bagged. The pharmacy's SOP stated that prescriptions should be attached to dispensed medicines awaiting collection.

On checking the pharmacy system, electronic prescriptions for the dispensed medicines awaiting collection had all been claimed for payment, before they were collected by people. The owner stated that the pharmacy's normal practice was to claim for payment as soon as they dispensed the medicines and the RP confirmed that this had been the pharmacy's practice for the past year. This was not the case for CDs according to the RP, she described CDs being prepared at the time people arrived to collect, this included Schedule 4 CDs. There was no information about how fridge items were

identified.

The pharmacy used owing slips for most prescriptions that were owed, and these were kept separately until the stock arrived. However, generated labels were seen attached to dispensed bulky items/MDS trays that were awaiting-collection. There was a risk that if these became detached or lost, then the only record showing that the medicine was owed would also be lost.

MDS trays were supplied to people who found managing their medicines difficult after the GP assessed this. Pharmacists assembled trays and self-checked them because of the lack of staff available. The pharmacy ordered prescriptions on behalf of people with trays, when these were received, details on prescriptions were cross-referenced against individual records to help identify changes or missing items. Queries were checked with the prescriber and audit trails were maintained to demonstrate this. All medicines included in trays were de-blistered and removed from their outer packaging. Warfarin was provided separately. The pharmacy required the person's International Normalised Ratio (INR) level before repeat prescriptions were released from the GP surgery. This information was retained to demonstrate that relevant checks were occurring. Mid-cycle changes involved trays being retrieved and new trays supplied.

Descriptions of medicines within trays were not provided and Patient Information Leaflets (PILs) were not routinely supplied. Trays were sometimes left unsealed overnight. One elderly person received valproate inside trays, originally this was four weeks at a time and now, the RP was supplying two weeks at a time, she held some knowledge about the stability of this medicine and explained that the pharmacist prescriber at the GP surgery had requested this because of the person's dose changes. There was no information documented to verify this or risk assessments for this situation carried out. The RP was instructed to seek further guidance and information about this.

The pharmacy provided a delivery service and in general, some audit trails to demonstrate this service were maintained. The records were created electronically, printed and the paper copy was used to obtain people's signatures. However, these were not stored in an ordered manner, they could not all be easily located as they were mixed in amongst invoices and other paperwork. Fridge items were highlighted on the record and delivered first. Details about CDs were not always highlighted, and this meant there was not a clear audit trail to identify when these medicines were delivered and who they were supplied to.

The owner and his uncle obtained people's signatures when they were in receipt of their medicines. There was a risk of access to confidential information from the way people's details were laid out. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and medicines were not left unattended unless prior consent was obtained. The record showed that some medicines were posted, the owner was aware of risks such as pets or children obtaining the medicines, he stated that he knew all the people using the service, but the pharmacy was not regularly asking/making relevant checks or documenting details to support that this had occurred.

Staff were aware of risks associated with valproate. There was literature present to provide to people and a poster on display to highlight the risks. According to the RP, there were no females in the at-risk group, identified as having been supplied the medicine. Other than prescriptions for warfarin, prescriptions for other higher-risk medicines were not routinely identified to enable pharmacist intervention, counselling or checking of relevant parameters to routinely occur.

The owner described sourcing medicines for the pharmacy from licensed wholesalers such as Alliance Healthcare, AAH, Colorama, Axis Medicare. Unlicensed medicines were obtained through Colorama or Alliance. Some invoices were seen but these were not stored in an organised manner. The owner stated

that some invoices for CDs were stored at the pharmacy, others were stored off-site in his garage. The team was not yet complying with the European Falsified Medicines Directive (FMD). The pharmacy was not registered with SecurMed, there was no guidance information present, software in place or relevant equipment. The owner stated that he had signed up to the specific software, but he did not think it was a legal requirement to be complying with this process.

Some medicines were seen to be stored in a disorganised manner. The RP described checking medicines for expiry regularly, every three months but the schedule to demonstrate this was last completed in 2017. This process was not being followed in line with the pharmacy's SOP. Short-dated medicines were identified using stickers and there were no date-expired medicines seen. In general, CDs were stored under safe custody and medicines in the fridge were stored appropriately.

There were loose blisters present, mixed batches seen and some tablets de-blistered and placed loose into the original cardboard box. The pharmacy's stock levels were observed to be high in comparison to their volume of dispensing. This included the amount of stock received for their monthly order. Both the pharmacy owner and the SI received drug alerts on their personal emails or through wholesalers, the pharmacy's email account could not be accessed by the owner at the point of inspection and this meant that in the absence of these two, other staff could not receive or check for alerts. Both the RP and owner explained the process as checking for affected stock and acting as necessary. This was the case seen for a recent alert. However, there was no audit trail to demonstrate the process.

Once accepted, the team stored most returned medicines requiring disposal within receptacles. Random returned medicines were seen in the stock room at the rear and for no apparent reason, they were placed close to dispensed medicines and the pharmacy's stock. It was not clear that they were patient returns until the inspector asked the owner about them. Staff were not segregating hazardous or cytotoxic medicines or removing confidential information from returned medicines before they were placed in receptacles.

Some staff could not recognise all cytotoxic and hazardous medicines and were unaware that they should be disposing of them using different waste bins. A list to identify these was seen amongst the pharmacy's SOPs but was not being used by the team. People bringing back sharps for disposal, were referred to the local GP surgery. Returned CDs were brought to the attention of the RP before being segregated in the CD cabinet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current versions of reference sources and relevant equipment were seen. This included clean, crown stamped conical measures for liquid medicines, as well as counting triangles and a separate one for cytotoxic medicines. The team described using the NPA's information services if further information was required.

Computer terminals were positioned in a way that prevented unauthorised access. Staff used their own NHS smart cards to access electronic prescriptions and took them home overnight. The pharmacy team used cordless phones, and this helped conversations to take place away from the retail space, if required. The dispensary sink used to reconstitute medicines could have been cleaner. There was hot and cold running water available. The fridge appeared to be operating appropriately and the CD cabinet was secured in line with legal requirements.

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.