General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dillons Pharmacy, 17 Church Road, Acton, LONDON, W3 8PU

Pharmacy reference: 1041390

Type of pharmacy: Community

Date of inspection: 20/09/2021

Pharmacy context

The pharmacy provides a range of services from its premises including dispensing prescriptions for people at home and for the residents of residential and care homes. It also has an on-line prescribing and supply service which it provides through its Express Pharmacy website https://www.expresspharmacy.co.uk . All of Express Pharmacy's prescriptions are prescribed by its pharmacist independent prescriber (PIP) who prescribes these medicines at a distance for a range of conditions. The pharmacy has a small selection of over-the-counter medicines and other pharmacy related products for sale from its premises. And it provides a range of other services including a flu vaccination service. The inspection took place over three different dates and included a physical onsite inspection on 20 September 2021 and 13 October 2021. And a remote inspection over Microsoft Teams on 26 November 2021. The inspection took place during the COVID-19 pandemic at a time when restrictions had largely been lifted in England.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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's procedures for identifying and managing the risks associated with its internet prescribing and supply services (Express Pharmacy) are inadequate.
		1.2	Standard not met	The pharmacy is unsatisfactory in that it doesn't review and monitor the safety and quality of its internet prescribing and supply service (Express Pharmacy)
		1.3	Standard not met	The pharmacy does not define the roles and responsibilities of team members supplying its internet prescribing and supply service. And the level of responsibility it gives its team members are not aligned to their skills, training and job role. And so, its procedures for the prescribing and supply service are inadequate and unsafe.
		1.6	Standard not met	The pharmacy's internet prescribing and supply service doesn't keep the records it is required to keep .
		1.8	Standard not met	The pharmacy's internet prescribing and supply service does not have adequate procedures to protect the safety of vulnerable people.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy's Express Pharmacy prescribing and supply service uses a prescriber who is not adequately trained for the services he provides. And he does not keep his knowledge up to date. The prescribing and supply service does not adequately use the skills and knowledge of the responsible pharmacist. And it is delivered by insufficiently trained staff.
		2.3	Standard not met	The pharmacy owner does not properly support its responsible pharmacists to fulfil their role. And it is inadequate in that it does not address their concerns.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's website for its prescribing service does not comply with general Pharmaceutical Council (GPhC) guidance.
4. Services,	Standards	4.2	Standard	The pharmacy's procedures for its internet

Principle	Principle finding	Exception standard reference	Notable practice	Why
including medicines management	not all met		not met	prescribing and supply service are inadequate. And so, it doesn't provide the service safely. The pharmacy does not have adequate prescribing policies and procedures to help its prescriber to deliver a safe and effective prescribing service. And its prescribing service does not follow appropriate clinical guidelines.
		4.3	Standard not met	The pharmacy does not do enough to ensure that all the medicines it purchases are satisfactorily accounted for. It does not ensure that medicines which can be abused are adequately monitored and purchased in appropriate quantities. The pharmacy does not ensure that all of the medicines it purchases will be supplied safely for the benefit of people's health.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy's internet prescribing and supply service, Express Pharmacy, doesn't have all the procedures it needs to help make sure the service is safe or effective. And its procedures for identifying and managing the risks associated with the service are inadequate. It doesn't review and monitor the safety and quality of the service. And it doesn't keep all the records it is required to keep. The prescribing and supply service does not adequately use the skills and knowledge of the responsible pharmacist. And it does not protect the safety of vulnerable people. And so its procedures for the prescribing and supply service are inadequate and unsafe.The main pharmacy keeps the records it needs to by law. And it has insurance to protect people if things do go wrong. The pharmacy has adequate written procedures in place for its face-to face activities to help ensure that its team members work safely. And it generally keeps the records it needs to for its main day-to-day services. Members of the main pharmacy team review the dispensing mistakes they make and learn from them to try and stop them happening again. They can explain what they do, what they're responsible for and when they might seek help. They generally know how to protect vulnerable people. The pharmacy has adequate procedures for people to provide feedback to help improve its services. And it keeps people's private information safe. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic.

Inspector's evidence

The pharmacy provided most of its face-to-face services from its main dispensary, consultation room and medicines counter area. And its small retail area. Its online private prescribing service was provided through the pharmacy's Express Pharmacy website. The prescriber for the service was the pharmacy's superintendent (SP) who was also a pharmacist independent prescriber (PIP) and a director of Carecamp Ltd., the owner of Dillons pharmacy. Express Pharmacy prescriptions were generated remotely. And the pharmacy had a separate area at the rear of its premises from where it dispensed and dispatched these prescriptions. Staff accessed Express Pharmacy prescriptions through a computer system located in the same area. This computer system was separate to the pharmacy's main computer system. The pharmacy's premises occupied two floors. And on the ground floor it had several small, open rooms which were connected to one another. Not all the rooms were on the same level. And so, team members could work appropriately distanced from one another for most of the time. The pharmacy had placed hand sanitiser at different locations in the pharmacy for the team and other people to use. The team had a regular cleaning routine and had access to personal protective equipment in the form of gloves and masks.

The main pharmacy dispensed and supplied medicines from prescriptions received from local prescribers. And it delivered them to people who were unable to collect them. The team highlighted the locations of some look-alike and sound-alike drugs in the dispensary to reduce the chances of picking the wrong product. Team members tried to keep the dispensing workstations tidy. They used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products and they initialled each dispensing label. Assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who also initialled the dispensing label. They recorded their dispensing mistakes and reviewed them periodically. But their records did not contain much detail. Team members agreed that records should identify what could be done differently next time to prevent mistakes and promote continued

improvement. They agreed also that mistakes should be discussed regularly within the team. And they recognised that it was important to learn as much as possible from mistakes to help prevent them from happening again.

While the pharmacy generally managed risks associated with its day-to-day dispensing activities, it had not adequately identified the risks associated with the purchasing of large volumes of codeine linctus and Phenergan elixir which had been ordered through the pharmacy by head office personnel. And while there was no evidence to show that codeine linctus or Phenergan elixir had been supplied inappropriately to any face-to-face customers at the pharmacy, the pharmacy had not been able to account for the purchases or verify the reasons for the purchase of these items. This suggests that the risks associated with purchasing large volumes of products liable to abuse had not been adequately assessed or considered by the pharmacy's owners and its directors, including its superintendent. And it appeared that they had not provided the team and the RP with an explanation of its reasons for using the pharmacy's accounts for purchasing these items.

The Express Pharmacy's business model was to prescribe and supply people with medicines which they may or may not have had before. People wishing to use the pharmacy's prescribing service needed to register with them on the website and complete a consultation questionnaire. The consultation questionnaire for each medicine was tailored to a specific licensed indication, for instance, norethisterone for period delay and zolmitriptan for migraine. The prescriber issued a prescription based on the successful completion of the questionnaire. After he had authorised a prescription, he uploaded it to Express Pharmacy's bespoke online system, along with an automatically generated prescription label and an address label. Once at the pharmacy it was viewed by an Express Pharmacy dispensing assistant (DA) who was also a trainee technician. And then it was dispensed by a second DA. The RP on duty at the pharmacy premises checked the labels produced against the product and the address label. The DA who had labelled the medicine then packed the medicines up ready for posting. But the RP did not necessarily see the Express Pharmacy prescriptions she was checking against. And while she could access the system and view the prescription, this was not part of the routine checking process. The procedure was designed for the RP to check the product against the prescription label and the packaging label only and not necessarily the prescription itself. And so it did not, provide the RP with the opportunity to easily carry out a clinical check of the prescription or check the item dispensed against it.

The prescriber had placed limits on the number and frequency of supplies for several of the medicines available. This was designed to help prevent people from getting certain medicines too many times, or to help prevent them from getting a medicine within an inappropriately short time frame. When these limits had been reached the prescription generated by the prescriber would be placed in a 'staff action queue'. The DA trainee technician could view the prescriptions in the staff action queue and she could then reject them. But decision to make a supply or reject it is a clinical one. And the limited clinical knowledge of a DA or trainee technician would not generally provide them with enough skills to make this type of decision. These decisions are generally considered to be part of the prescribing process and so are best made by the prescriber before the prescription is processed by the dispensing team. The prescriber would also be the one to let people know why he wouldn't be issuing a prescription, so that the he could signpost them and make sure they got the most appropriate care and treatment. The clinical basis on which these limits had been set was also unclear. And, there is evidence to show that, in any case, the limits were not always followed. People had been supplied with more than three Ventolin inhalers within two months, which did not match up with the pharmacy's limits. The over-ordering of Ventolin inhalers could indicate that the people ordering them were not controlling their asthma well. This means that they should be signposted or counselled appropriately for the benefit of their health. The prescriber was unsure if dispensing staff would be able to detect if

someone had changed their answers on the questionnaire to get the medicine they wanted. He was unsure what level of access dispensing staff had to the IT system. And he was unsure if they were blocked from amending a prescription. The inspection found that the pharmacy's procedures for the service focused on systems and procedures rather than safe and effective outcomes for patients.

The SP who was also the prescriber, had produced a risk assessment for Express Pharmacy services. But it was risk assessment for the business overall. And it was primarily concerned with data protection, patient confidentiality and business continuity. It did not have any risk assessments of prescribing protocols for the medicines prescribed. Its procedures covered the systems and processes for prescribing and supply but did not adequately address the potential risks to people obtaining medicines through the internet. The prescriber believed that people's answers to the questionnaires provided him with enough information to provide a prescription appropriately. But evidence gathered from prescribing records showed that much of his prescribing did not follow good practice guidance. And it did not follow UK clinical and professional guidelines.

The main pharmacy had a set of SOPs to follow for its face-to-face services. And its team members had read the SOPs relevant to their roles. The SOPs had recently been updated and team members were in the process of reading the updated SOPs. Support staff appeared to understand their roles and responsibilities and were seen consulting the RPs on duty during both physical inspections when they needed their advice and expertise. The RPs present at the premises during both physical inspections had placed their RP notices on display showing their names and registration numbers as required by law. But the pharmacy did not have a thorough set of SOPs for its Express Pharmacy service. Express Pharmacy SOPs covered the general systems and procedures to follow and the general prescribing process. But they did not cover procedures for prescribing and supplying specific medicines. Nor did they identify when further intervention may be required to provide people with the most appropriate treatment and care.

The Express Pharmacy service had not conducted any ID checks. And so it could have been supplying medicines to people who were not who they said they were. A lack of checks also made it difficult to identify the appropriateness of a medicine for the person requesting it. This was particularly relevant for several medicines such as emergency hormonal contraception (EHC) or medicines for urinary tract infections. People were also asked to provide consent to contact their General Practitioner (GP). But the risks associated with people not providing their consent hadn't been fully considered. Particularly for medication that required on-going monitoring and follow up. Or for when someone may need further clinical or medical intervention. And none of the documentation seen gave an indication of the maximum quantities of medicines that should be prescribed for individual patients. The pharmacy did not have a prescribing policy. And it did not have information on clinical processes, pathways or national guidance for the prescriber to follow. In addition the pharmacy had not carried out any audits of its prescribing practice. This meant that the safety, effectiveness and quality of the prescribing service wasn't appropriately monitored.

People could give feedback on the quality of the pharmacy's services overall. They could do this face to face or they could do it online. The pharmacy had a complaints procedure. In general, the team sought feedback from conversations with people as well as staff at the homes it supplied medicines to. And people could comment about the Express Pharmacy service on its website. Concerns about the pharmacy's prescribing service mainly involved delays in people receiving their medicines. Or changes to the brand supplied. The pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) online. But customer concerns were generally dealt with at the time by the regular pharmacists or the superintendent PIP.

The pharmacy had professional indemnity and public liability arrangements in place to cover its services.

The pharmacy kept a record to show which pharmacist was the RP and when. And these were generally in order. The pharmacy had a controlled drug (CD) register which was in order. The pharmacy kept electronic records for the emergency supplies it made. And these too were generally in order. The pharmacy also kept its private prescriptions records electronically. And it had concurrent private prescription records for Express Pharmacy prescriptions and the main pharmacy. Express Pharmacy's bespoke IT system recorded details of what had been prescribed to people and when. But the prescriber did not keep records of consultations or his decision-making processes. And while the RP could access people's completed questionnaires, the system was set up so that questionnaires weren't routinely shared with her. This limited the RP's ability to assess the clinical appropriateness of Express Pharmacy's prescriptions. Particularly when the process allowed decisions about supply to be made after the prescribing process and before supply, in some cases.

The pharmacy had an information governance policy in place. And its team members kept people's private information safe. People using the pharmacy's services couldn't see any other people's personal information. The pharmacy had arrangements to make sure its confidential waste was collected and then sent to a centralised point for secure destruction. The pharmacy had safeguarding procedures. And the prescriber and the RPs had completed an appropriate safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. And they had the contacts they needed if they wanted to raise a safeguarding concern. Evidence showed that the prescriber had initiated medications for weight loss. But he couldn't show any evidence of training or competence for this area of his prescribing practice. The lack of ID checks and up-to-date and appropriate prescribing protocols meant that there was a lack of safeguarding for vulnerable people. This included people seeking medication for weight loss and those requesting the contraceptive pill or EHC.

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

Summary findings

The pharmacy's Independent Pharmacist Prescriber (PIP) is not adequately trained for the services he provides. And he does not keep his knowledge sufficiently up to date. The pharmacy owner does not properly support pharmacists to fulfil their responsibilities. And does not do enough to address their concerns. But the pharmacy team manages its workload for its face-to-face services safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can maintain the quality of the pharmacy's services.

Inspector's evidence

The inspector conducted the physical inspection of the premises during the pharmacy's usual trading hours. On the first visit the RP was a locum who was covering the regular RP's annual leave. The locum RP had worked at the pharmacy before. On the second visit the regular RP was present. The regular RP had worked at the pharmacy for approximately two years, working Monday to Friday and some Saturdays. Remaining Saturday cover was provided by several pharmacists including one of the pharmacy's other directors who was also the SP of another pharmacy business, Richard Adams Pharma Ltd. Richard Adams Pharma Ltd. had close links, through its directors, to Dillons Pharmacy. Saturday cover was also provided occasionally by the regular RP at one of the pharmacies owned by Richard Adams Pharma Ltd.

The pharmacy had an additional five team members who provided face-to-face services. This included two trainee pharmacists who alternated their training time between the pharmacy and a local GP practice, a technician, a trainee technician, a trainee dispensing assistant and a trainee healthcare assistant (HCA). Express pharmacy services had its own DA trainee technician and trainee DA. The trainee DA had been registered on her course after the inspector's first visit to the pharmacy. The trainee technicians and trainee DAs are referred to as DAs in this report. The prescriber wasn't based at the pharmacy premises. The regular RP managed the pharmacy and its team, and she supervised and oversaw the supply of medicines and advice given by it. The newly employed HCA described the questions she would ask when selling an over-the-counter medicine. She explained that she would refer requests for medicines to a pharmacist until she had completed the relevant training. In the meantime she was encouraged to ask questions and familiarise herself with new products.

On both physical visits to the pharmacy team members were seen to work effectively with one another. The pharmacy had a close-knit team who worked regularly together. The daily workload of prescriptions was in hand and customers were attended to promptly. RPs were generally able to make day-to-day professional decisions in the interest of patients. RPs generally felt that they could discuss their concerns with the owner. But when the regular RP had raised a concern about the pharmacy's frequent receipts of large volumes of codeine linctus and Phenergan elixir the directors including the SP had not afforded her with sufficient or accurate information about the orders or the purpose for which they were ordered. And they had not afforded her with adequate recognition of her role and responsibilities when ordering high volumes of medicines delivered to the pharmacy. They had not supported her with her responsibilities for ensuring the accuracy and appropriateness of prescriptions from the Express Pharmacy service. The dispensing and supply of Express Pharmacy prescriptions was more of an automated process between the prescriber and dispensing assistants with little intervention invited from the RP. The remaining team involved in delivering express Pharmacy services generally

worked separately to those delivering the pharmacy's face-to-face services.

The prescriber was unsure what was required of him regarding his competencies. He had qualified as a PIP in September 2016 with competency in prescribing for Asthma. And after qualifying had worked with a designated medical prescriber in a GP surgery. Since then he had not conducted any training specific to prescribing. And had not sought an independent review of his prescribing practices from a medical prescriber. Nor had he audited his prescribing against current prescribing guidelines. But he had completed various pharmacy training courses. This included a course run by Health Education England (HEE) on antimicrobial stewardship for community pharmacy. And several courses run by Centre for Pharmacy Postgraduate Education (CPPE). The CPPE courses completed included men's health, emergency contraception and weight management. He described how he believed that the experience he had gained through the provision of many recorded and unrecorded consultations within community pharmacy had provided him with the competency to provide the prescribing services through Express Pharmacy. But a lack of prescriber specific training meant that he was prescribing outside his competency. And so, as a prescriber he could do much more to provide assurance that he was competent in the treatment areas he prescribed for. For example, there were some treatment areas, including urinary tract infections and travellers' diarrhoea where there was evidence to show that he was not prescribing according to national prescribing protocols.

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

Summary findings

The pharmacy's website for its prescribing service allows people to choose a prescription-only medicine before beginning a consultation with a prescriber. And so it does not comply with general Pharmaceutical Council (GPhC) guidance. But the pharmacy's premises provide a suitable environment for people to receive its services. They are tidy and organised and sufficiently clean and secure. The pharmacy provides an adequate and secure environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy's premises had a small retail area and a small dispensary. And it had a consultation room. The team followed a cleaning routine to ensure that contact surfaces were clean. And so, the pharmacy was generally clean and tidy. The dispensary had a single run of dispensing bench in the main dispensary and a separate run of dispensing bench in one of the small rooms behind, which was used for dispensing and checking multi-compartment compliance packs. Team members generally tackled one task at a time, and they were careful to complete each prescription in a timely manner to avoid a build-up of prescriptions. The pharmacy had an additional room upstairs which was used as an office. It was used as the head office for pharmacies owned by Richard Adams Pharma Ltd. and Carecamp Ltd. Overall, the pharmacy was clean and tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

The pharmacy's website for Express Pharmacy provided some of the information it needed to in line with GPhC guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. But a person could choose a prescription-only medicine before there had been an appropriate consultation with a prescriber. And the website didn't make it clear that decisions about treatment were for both the prescriber and the person to jointly consider during the consultation, but the final decision would be the prescriber's. The pharmacy had a consulting room for the face-to-face services it offered. And this could be used if people needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. And its contents were kept secure. The pharmacy had the sinks it needed for the services it delivered. And each sink had a supply of hot and cold water. Members of the pharmacy team were responsible for keeping the premises clean and tidy.

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

Summary findings

The pharmacy does not do enough to ensure that all the medicines it purchases are satisfactorily accounted for. It does not ensure that medicines which can be abused are purchased in appropriate quantities. And it does not ensure that these medicines will be supplied safely for the benefit of people's health. The pharmacy doesn't provide its prescribing service safely. The pharmacy does not have adequate prescribing policies and procedures to help its prescriber to deliver a safe and effective prescribing service. And its prescribing service does not always follow relevant clinical guidelines. So, people using this service could be put at risk. The pharmacy provides services that people can access. It gets its medicines and medical devices from appropriate sources. And it stores them appropriately and securely. It also disposes of people's unwanted medicines properly. Members of the pharmacy team broadly carry out the checks they need to. So, they can make sure the pharmacy's medicines and devices are safe and fit for purpose.

Inspector's evidence

The pharmacy's premises had a sign at its entrance advertising the times of opening. It had step-free access from the pavement outside. And the customer area was clean and tidy and free of obstacles. This made access easier for wheelchair users and those with mobility difficulties. The pharmacy had a small seating area for people to use when they wanted to wait. This was set away from the counter to help people keep apart. And it had a delivery service for people who found it difficult to visit the pharmacy or had no-one to collect their prescriptions for them. People accessed the pharmacy's prescribing service through its Express Pharmacy website. And if they had questions or concerns about the medicines they ordered, they could raise these via a chat facility on the prescribing system. The chat facility was generally managed by the Express Pharmacy trainee technician DA or the prescriber. This was generally used when a person's order was rejected. People could also contact the pharmacy. And, if needed, the pharmacy team could refer requests relating to the prescribing service to the prescriber. The prescribing service prescribed medicines for a range of conditions including migraine, period delay, weight loss, Cystitis, travellers' diarrhoea, men's health, women's health and sexual health.

The only prescribing records were in the form of the private prescription record. The PIP informed the inspector that he did not generally make prescribing notes or record the reason for his prescribing decisions. Records supplied by the PIP following the inspection indicated that the pharmacy had supplied 9613 prescription items in the preceding three months (September to November 2021). Some of the medicines the PIP prescribed were high-risk because they required specialist services to determine the appropriateness of supply. Others required monitoring so that the identity of the person being treated could be verified. This was necessary to help safeguard vulnerable people and prevent the potential for abuse. Others required monitoring and laboratory investigations to make an informed decision about the continuation of treatment and to ensure the safe and effective delivery of care. But the pharmacy was not able to provide any evidence that this was happening. Examples include Ella-One for emergency hormonal contraception, Saxenda injections for weight loss, ciprofloxacin and azithromycin for travellers' diarrhoea and nitrofurantoin and trimethoprim for urinary tract infections.

The inspector concluded the following prescribing patterns from the three months of prescription

records supplied by the prescriber. This was not a full analysis of all the items prescribed, but data gathered for specific items where there appeared to have been inappropriate prescribing, outside current guidelines and inadequate monitoring and control over repeat prescription requests. The pharmacy made 456 separate supplies of ciprofloxacin in total. The prescribing of ciprofloxacin was based on a flawed questionnaire for travellers' diarrhoea as it did not follow current guidelines for managing the condition. And ciprofloxacin was no longer a recommended treatment due to emerging bacterial resistance and adverse effects profile. Despite this 40 people had been supplied with ciprofloxacin on at least two occasions between 1 September and 30 November. Of those, four or more had been sent three supplies, three sent four supplies, two sent five supplies, one sent six supplies and one sent seven supplies. This repeated supply of the same antibiotic to the same people went against the principles of antimicrobial stewardship. And did not consider the need for referring the individual to an appropriate specialist for further investigation and treatment. In addition it indicated the inappropriate prescribing of antibiotic for travellers' diarrhoea. Prophylactic antibiotics for travellers' diarrhoea shouldn't be offered routinely and should only be prescribed for individuals who are at high risk of developing it and/or at risk of harm from its complications. The travellers' diarrhoea questionnaire was clinically inappropriate as it didn't assess either the travel destination risks or the individual health status which might put them at great risk of acquiring travellers' diarrhoea and/or its complications.

The pharmacy made a total of 237 supplies of Azithromycin during the same three-month period. In excess of 20 people (one in Estonia) had been supplied with azithromycin on at least two occasions. Of those, four people (one in the USA) have been sent three supplies and one sent four supplies. The prescriber had issued repeat prescriptions without seeking a test of cure or signposting for further investigation. This applied whether the prescriber was treating Chlamydia or whether inappropriately prescribing azithromycin for travellers' diarrhoea, as described previously for ciprofloxacin.

The prescriber had prescribed 850 separate supplies of trimethoprim for treatment of a UTI. Over 40 people had been supplied with trimethoprim on at least two occasions between 1 Sept and 30 November. Of those, three had been sent three supplies and one sent five supplies. two had three supplies in one month. On two or more occasions the name of the person for whom Trimethoprim has been prescribed appeared to be male. While a person's name cannot always be assumed to indicate suitability, there was no evidence to show that further checks had been made by the prescriber. So this should have warranted further investigation and intervention from the prescriber. And where appropriate, the patient should have been referred for further assessment in view of the similarities between the symptoms of bladder or renal cancer in males or prostatitis.

The pharmacy had made 560 separate supplies of nitrofurantoin for treatment of a UTI. 41 people had been supplied with Macrobid (nitrofurantoin) on at least two occasions between 1 Sept and 30 November. Of those, five had been sent three supplies and two sent four supplies. One person had also been sent two supplies of trimethoprim. As for trimethoprim more than one prescription appeared to have been for a male and so this too should have been subject to further checks and/or referral. As with other antibiotics the PIP had not followed up his diagnosis and prescribing with a test of cure so that the patient could be referred for further treatment or clinical intervention if necessary. He had not followed the principles of antimicrobial stewardship by giving adequate consideration to the drug of choice according to the area in which a person lived. And by repeating the prescription had not adequately considered that the patient's condition may be resistant to the antibiotic and require referral for further diagnosis and treatment. This could lead to kidney problems, pyelonephritis, or sepsis if the infection remains untreated.

Express Pharmacy's risk assessment stated that people should not be able to make more than two

purchases of Ventolin inhalers in a six-month period. But evidence showed that the pharmacy had made repeat supplies within three months or less for many patients. And it had also made repeat supplies within the same month for three or more patients. Ventolin contains salbutamol which is a short-acting bronchodilator routinely used for people with asthma or chronic obstructive pulmonary disease. These conditions require follow up and monitoring. But there was no evidence that people requesting Ventolin inhalers were counselled on how to manage their condition or counselled on the use of preventative inhalers. The service's automated system for flagging frequent requests did not appear to be used effectively. The prescriber didn't set the maximum quantity that could be prescribed for certain types of medicines such as antibiotics. And he hadn't set limits on the frequency of supplies for certain conditions such as cystitis. He also did not have a risk assesment or prescribing policy which covered restrictions on supplies or which included how he would test that the condition had been cured. The pharmacy's overall risk assessment mentioned that the prescriber should be aware of the risks of supplying against repeat requests for Ventolin inhalers and antibiotics. And yet there was substantial evidence to demonstrate that he had done just that and supplied against repeat requests without adequate intervention.

The prescriber prescribed Ella-One on 626 occasions between 1 September 2021 and 30 November 2021. Ella-One is a form of EHC. The lack of ID checks carried out gave rise to safeguarding concerns, and the potential for abuse. The pharmacy supplied 278 prescriptions for Saxenda (liraglutide) injections for weight loss. The prescriber had prescribed more than 40 people with the injections in varying quantities, on at least two occasions between 1 Sept and 30 November 2021. Of those, five had been sent three supplies, four people had four supplies, and one person eight supplies. People using Saxenda needed to be monitored to ensure that it was appropriate for them and that they remained well while taking it. They should also have been monitored for an appropriately managed level of weight loss. The prescriber had not done any additional training on the prescribing of this drug which was usually prescribed through specialist weight management services. In addition Saxenda has been prescribed only on the basis of answers people gave to the questionnaire. This is a concern as the system allowed people to change their answers to the questions in order to obtain the Saxenda and a lack of ID checks meant that people could order additional supplies using a different identity. There was also a lack of follow up counselling and advice regarding diet and exercise. The lack of monitoring and intervention by the prescriber left the supply of Saxenda liable to abuse. The prescriber had not kept records of his decision making and so there was no evidence to show that he had requested further information nor was there evidence of results and monitoring to support his clinical decision making. Or evidence that people had been provided with appropriate counselling.

The pharmacy's prescribing policy didn't contain any information on clinical pathways, guidelines or procedures that the prescribers needed to follow. While people were asked to provide the details of their regular doctor during the consultation process, this wasn't mandatory, and supplies were made without the pharmacy notifying the doctor of the treatment requested. This meant there was a risk that patients were prescribed medications which required monitoring and weren't appropriately followed up. So, the pharmacy could do more to mitigate the risks around the monitoring and follow-up of people who were taking medicines, such as an antibiotic, an inhaler or a medicine for weight loss. This would help make sure there was a transfer of care from the pharmacy's prescriber to the person's regular clinician. There was also evidence that overseas patients were prescribed medicines that required on-going monitoring. But it was unclear if these patients' regular clinicians were notified when a decision was made to prescribe these medicines.

The pharmacy's online consultation did not require people to give their permission to access their Summary Care Records (SCR). The pharmacy's prescriber did not have the necessary information needed to make an informed decision before a medicine could be supplied overseas. And, for example,

this included confirming whether the patient understood English, validating the patient's medication history and obtaining proof of current prescription. This meant there was a risk that people outside of the UK, including overseas patients, could obtain, or continue to take, medicines that weren't suitable for them without oversight of their regular prescriber. The pharmacy used Royal Mail's tracked postal service to deliver medicines ordered through the company's website to people living in the UK and overseas. The handover of assembled prescriptions to the delivery agent occurred at the pharmacy premises. And an audit trail was generally kept for each postal delivery. The pharmacy used plain packaging to deliver these medicines.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately. But it was unable to adequately account for some of the medicines purchased. Personnel from the pharmacy's head office had purchased high volumes of codeine linctus and Phenergan elixir which were not required by the pharmacy for sale or supply against prescription. Instead, head office personnel removed them from the pharmacy after they had been delivered to it. The pharmacy's head office team had not explained its reasons for ordering the stock. Nor had it explained where the medicines were going or who they were being supplied to. After receiving an email from the London CD accountable officer (CDAO) alerting the pharmacy to the potential abuse of a concoction containing both these liquids, the regular RP asked the directors what the stock was being used for but did not receive a satisfactory answer. She understood that the orders had stopped but the inspector received evidence to suggest that the purchases had continued. Stock on the shelves was generally tidy and organised. And team members date-checked the pharmacy's stocks regularly. And they kept records to help them manage the process effectively. In general, short-dated stock was identified and highlighted so that it could be easily spotted before it was dispensed. The RP and the inspector discussed the importance of removing stock which had reached, or was close to, its expiry date. The team put its out-of-date and patient returned medicines into dedicated waste containers. And it stored items in a CD cabinet and fridge as appropriate. Team members monitored the pharmacy's fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy received alerts from the MHRA which helped them to respond promptly to drug recalls and safety alerts.

The pharmacy supplied COVID-19 rapid lateral flow tests from its premises, so that people could use them at home. This was to help find cases in people who may have no symptoms but are still infectious and can give the virus to others. The pharmacy used a disposable system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be repackaged. It generally provided a brief description of each medicine contained with the compliance packs. But patient information leaflets weren't always supplied. So, people didn't always have the information they needed about their medicines. The pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items, such as a CD or a refrigerated product, needed to be added. Members of the pharmacy team knew that valproate mustn't be used in anyone in the at-risk group unless there was a pregnancy prevention programme in place. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the resources it needed for when it dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices tidily on the shelves within their original manufacturer's packaging. The pharmacy team checked the expiry dates of medicines at regular intervals. And it recorded when it had done these checks. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy generally kept its out-of-date and patient-returned CDs separate from in-date

stock. And its team kept a record of the destruction of CDs people returned to it. The pharmacy had procedures for handling the unwanted medicines people returned to it. These medicines were kept separate from stock and were placed in a pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules. And it had the appropriate measures for measuring liquids. And the equipment it used was cleaned after use. Team members had access to a range of up-to-date reference sources. And they could access PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies. The pharmacy had several computer terminals which had been placed at individual work- stations around the pharmacy. Computers were password protected. And team members had their own smart cards to ensure that they could maintain an accurate audit trail. And to ensure that access to patient records was appropriate and secure.

The pharmacy had some plastic screens on its counter. It had hand sanitisers for people to use if they wanted to. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of this refrigerator. People's personal data was kept securely. And the pharmacy's website used a secure payment system. The pharmacy restricted access to its computers and patient medication record systems. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team.

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.