General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Davidsons Chemist, 10 Bridge Street, BALLATER, Aberdeenshire, AB35 5QP

Pharmacy reference: 1041651

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

This is a community pharmacy on a main road in a village. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. The pharmacy supplies medicines to care homes. It offers flu vaccination during the flu season and has recently started offering travel vaccination.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.1	Good practice	The pharmacy has arrangements in place to ensure that all team members share learning. And they pro-actively assess and manage risks associated with new services.
		1.2	Good practice	The pharmacy regularly and consistently records, reviews and learns from errors and incidents. Team members make changes to improve safety of the pharmacy services.
		1.4	Good practice	The pharmacy uses feedback from people to continually improve its services.
		1.8	Good practice	The pharmacy makes safeguarding interventions appropriately and documents these.
2. Staff	Standards met	2.1	Good practice	The pharmacy has contingency in place for changing staff levels and workloads. It reviews staffing levels. And it has succession planning in place.
		2.2	Good practice	The pharmacy provides new employees with a structured induction programme. It also provides learning time during the working day for training to all team members.
		2.3	Good practice	The pharmacy team can give many examples of interventions with positive outcomes for people. And this was observed.
		2.4	Good practice	All team members are comfortable sharing and discussing their mistakes and weaknesses. They use this knowledge to improve pharmacy services.
		2.5	Good practice	The pharmacy team have regular meetings to discuss patient safety, learning needs, raise concerns and make suggestions. Team members are able to share ideas. The pharmacist records notes of meetings.

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 proactively offers services to people that they would benefit from.
		4.2	Good practice	The pharmacy's services provide good outcomes for people. It helps people get the best from their medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team members follow processes for all activities to ensure that they are safe. Pharmacy team members record mistakes to learn from them. They use this learning to avoid the same mistakes happening again. The pharmacy asks people for feedback. And pharmacy team members use this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years or more frequently and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were clear about the role of an accuracy checking technician (ACT). She checked dispensing accuracy from all prescription types but did not check schedule 2 controlled drugs (CDs). She identified suitable prescriptions with the pharmacist's initials denoting a clinical check had been undertaken. And she had not already been involved in any aspect of that prescription, denoted by other team members' initials. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. This included a range of contact details for other pharmacies, head office, local businesses and other healthcare professionals and equipment including mobile phone and torch. The pharmacist risk assessed proposed new services. She described concerns identified when considering starting a travel vaccination service. These included lack of medical and vaccination history for people accessing the service. But following her training she was reassured that this was not a risk. She also considered the suitability of the consultation room and ability to deal with anaphylaxis. But these had been addressed satisfactorily previously when offering flu vaccination.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed and analysed these monthly and took action to prevent the same error happening again. The pharmacy used an electronic system to record incidents, and analysis was provided monthly. This enabled the pharmacist to identify trends or recurring incidents which were discussed at monthly team meetings. As an example she had identified that most errors involved items that had not been scanned. The scanning highlighted if the wrong item had been selected so team members were reminded to scan all packaging. In another example team members placed labels on shelves to highlight items involved in incidents such as trimethoprim. They also highlighted similar pack designs, with different strengths or contents. The pharmacy displayed a poster on the dispensary wall with items that head office wanted to be double checked for accuracy before passing for the final check. These included controlled drugs, cytotoxics and insulin. There was a space for the pharmacy to add its own examples such as salbutamol inhalers, amlodipine and amitriptyline. Some team members' names were noted against these demonstrating openness and sharing information. The pharmacist had carried out a root cause analysis using the '5 whys' template after a dispensing error had reached a patient. Team members devised an action plan to avoid repetition. And displayed this on the dispensary wall for reference. The pharmacy reviewed

other aspects of its services. It had trialled opening on public holidays as the area could be busy with tourists on these days. Pharmacy services would not otherwise be available in the area.

The pharmacy had a complaints procedure and welcomed feedback. It received a lot of positive feedback verbally and in writing. People had responded very favourably to the roll-out of a texting service notifying them when their medicines were ready for collection. GPs had commented positively about compliance and concordance being monitored for people on chronic medication (CMS) serial prescriptions. Which encouraged team members to continue doing this. Previously the pharmacy did not put tablet descriptions on multi-compartmental compliance packs. The team had discussed this at length following an incident when a doctor told a person to stop taking a tablet. But the person did not know which tablet that was. The pharmacy devised a template to note descriptions and attach it to the front of packs rather than including this information within the pack. People liked this, finding it easy to read and use. Several people had given positive feedback to the pharmacy.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They undertook annual training on this and safeguarding. And this had recently been completed. Several months previously the pharmacy had devised a new ‘sign-in’ sheet for external visitors. This provided an audit trail of visitors and helped to remind team members to ask for identification. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. They knew how to raise safeguarding concerns locally and had access to contact details and processes. The pharmacy displayed this information in a readily accessible area of the dispensary. It had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then it makes changes when required. This ensures skilled and qualified staff provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use the professional judgement to help people. Team members share information and can raise concerns to keep the pharmacy safe. They make suggestions to improve services. And they discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time accuracy checking technician (ACT) 30 hrs, one full-time supervisor who was a trainee pharmacy technician, two part-time pharmacy assistants (four days per week), one Saturday-only assistant who had recently started and was undertaking a twelve-week induction programme, and a part-time delivery driver from another branch. At the time of inspection all team members (except the Saturday-only assistant) were working. They followed a rota for working on the medicines counter. The pharmacy and superintendent pharmacist were monitoring staffing levels. They were planning for the trainee technician to provide cover for other branches once she was qualified, so there would probably be a need to recruit a front-shop supervisor. And the pharmacy had increased a team member's hours recently. Part-time team members were sometimes able to work extra hours to cover for absence.

The pharmacy was committed to providing time during the working day, and resources for training and development. The previous pharmacy manager had been in the pharmacy for many years. So, the current pharmacy manager realised there could be a challenge for her as there was an inevitable change for the team and community. She was keen to quickly develop her skills and role and described training and development she had undertaken. This included shadowing a practice pharmacist and working closely with GP colleagues to build relationships and increase skills. All team members had been trained in all processes and services in the pharmacy. And they could now all deliver all services. They all attended local and centralised training sessions. These included CPR and defibrillation training with the local fire brigade. When the pharmacist organised this, she invited locum and relief pharmacists for maximum coverage. There was a defibrillator located very close to the pharmacy. Other external training included ethical dilemmas, menopause and women's health, pain management, smoking cessation, and health literacy. All team members attended some of these, with a few individuals attending others. They discussed them and shared the learning with colleagues. Team members had to travel to a city around 40 miles away to attend some of these.

The pharmacy used individuals' skills to free the pharmacist as much as possible. The ACT undertook a lot of the accuracy checking. The pharmacy provided learning time during the working day for all team members to undertake regular training and development which was prescribed from head office. These were e-learning modules and team members could also select topics that they were interested in or felt the need for. The team discussed the learning as a group after team members had all completed the modules. The pharmacy had provided training in pharmacy services to all team members, so they were all competent to deliver all aspects of e.g. the chronic medication service. The pharmacy manager asked

team members during regular team meetings if they had identified any learning or development needs. They addressed these by shadowing colleagues or referring to SOPs or other documents or reputable websites.

The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. All team members demonstrated a friendly and professional manner when addressing people. The pharmacist always provided information and invited questions from people in a natural way when handing out medicines. An example was observed of the pharmacist fully engaging a person who was about to leave the pharmacy by asking how they were getting on with their medicines. She documented the conversation on the patient medication record. Several interventions were made related to medicines in short supply and these were also documented. Team members checked for identical or similar alternatives, confirmed with the pharmacist then contacted the prescriber. This usually resulted in a replacement prescription to ensure continuity of medicines for people. Several examples were described of appropriate interventions made for people in care homes being prescribed inappropriate acute or mid-cycle additions. All team members were able to query these with the pharmacist, and they liaised with another pharmacy who was usually making the supplies as noted below. Similar interventions were made by several team members for a variety of medicines for various people e.g. inappropriate prescribing of ibuprofen gel, wrong strength prescribed of a vaccination, and wrong eye drops prescribed.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these and concerns. The pharmacy manager encouraged all team members to discuss all issues openly with her or at the team meeting. Individual weaknesses were on a sheet on the dispensary wall regarding double checking and scanning items. Team members were comfortable with this and supported each other. They could make suggestions and raise concerns to the manager or area manager. A team member suggested adding a desktop application to all computers to easily access a supplier's online return system. The pharmacy manager had agreed this and it was adopted. Another suggested using 'two-dose' multi-compartmental compliance packs in addition to four-dose packs which had also been implemented, with positive feedback received from people using them. Team members contacted head office when they were concerned about short-dated prescription items which enabled re-distribution across the organisation. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this operations update and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The pharmacist made detailed notes of meetings for team members to refer to and reflect on. The pharmacy had a whiteboard and notice board used to share information such as training due, improvement ideas, local initiatives, operations updates, safety bulletins, achievements, and NHS communications. A recent NHS letter was informing pharmacies of a change of preferred product to a more cost effective one. The pharmacist liaised with the GP practice and prescribing changes were made once stocks were exhausted.

The company had a whistleblowing policy that team members were aware of. The pharmacy worked closely with head office personnel. An issue that had been raised and resolved was described. And the pharmacy had requested an additional computer to use in the staff area for training and administration. This was recently received and was in use. The team were shown plans for comment following a flood when the pharmacy had to be re-fitted.

The company provided figures for discussion for various parameters. Team members described how they used these to discuss services such as the chronic medication service (CMS). They were trying to

register everyone as they could see real benefits, so numbers were increasing. A team member explained that some figures highlighted issues with administration, paperwork or endorsing.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy services provided. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and first floor area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy had been badly affected by flooding in the village a few years ago. The ground floor was refitted following this creating a larger dispensary and consultation room.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. It was professional in appearance. The door was kept locked to prevent unauthorised access. The pharmacy kept its equipment in cupboards in the consultation room. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. It engages with the local community and participates in community events. The pharmacy provides services that local people and visitors want and need such as travel vaccination and advice about Lyme disease. The pharmacy team provides safe services. Team members give information to help people use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do when medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The delivery driver from another branch provided an essential delivery service to care homes. The pharmacy did not offer a routine delivery service because the pharmacist believed it was important to see people when they collected their medicines. This gave her opportunity to discuss any concerns or issues. She did arrange exceptional deliveries when there was urgent need.

The pharmacy was involved with the local community supporting charities, raffles and joining in community events. The pharmacy also supported Davidson's charity of the year with a variety of events and initiatives.

The pharmacy had worked closely with the GP practice during the flooding a few years previously which had strengthened relationships. While the premises were being repaired and re-fitted the pharmacy had operated from a room in the GP practice. Team members had built on these relationships since returning to the pharmacy premises. The pharmacy was in an area popular with visitors from home and abroad. Team members described administering first aid, and signposting to dental and medical services. The pharmacy received prescriptions for temporary residents, and these did not have postcodes which were required for labelling. So, they created a list of common postcodes and placed it beside computers which saved time.

Pharmacy team members followed a logical and methodical workflow for dispensing using the company SOP. The team member labelling printed all warning labels and shared them with the pharmacist to facilitate clinical assessment. Team members also used ‘point of labelling checklists’ to share information. So, the pharmacist undertook new medicines interventions giving advice when these were supplied. She used this opportunity to register people for the chronic medication service (CMS). Sometimes the pharmacist used the SBAR (situation, background, assessment, recommendation) documents commonly used within the NHS to share information with prescribers. An example involved a person recently started on an anticoagulant medicine. The pharmacist had followed up after five weeks and discussed the outcome with the GP, who discussed with a clinical specialist then changed the medication to a different one. This intervention could have prevented the person suffering an incident such as a stroke.

Team members initialled dispensing labels and prescriptions to provide an audit trail of who had been

involved at all stages of the dispensing process. The ACT checked any prescriptions that had been initialled by the pharmacist clinically assessing, and not initialled by herself as part of the dispensing process. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these the week before expected supply. It kept records of the dates of dispensing and collection. When people presented their first serial prescription the pharmacy asked them to bring in all their medication so that it could be synchronised. This enabled the pharmacist to monitor compliance and concordance going forward.

The pharmacy signed people up to its texting service. The pharmacy contacted people if they had not collected their medicines within a few days of the expected start date. A team member had contacted the GP practice recently when concerned about a person not collecting. This person had obtained a supply of medication in a different area due to circumstances. The pharmacy had left the dispensed medicines on the retrieval shelves for the next cycle and made a note on the patient medication record (PMR). The pharmacy was actively registering people for this service. All team members were trained to initiate this and gathered relevent information from people. The pharmacist used this to identify pharmaceutical care issues and identify people that could benefit from the smoking cessation service. She had developed a document with common phrases that she used to copy and paste information onto the PMR to record all interventions, advice and start conversations the next time the person was in the pharmacy. She used phrases that were easy to use with people, so that these could be delivered by any team member easily when supplying medicines, e.g. ‘noted that you are smoker – we can help to stop’. Team members saw these notes on bags and a computer screen as they were handing out medicines.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. All team members were competent and took turns to undertake this activity. The pharmacist undertook clinical assessments of the first prescriptions, then again following any changes. The team followed a well-documented process which allowed the ACT to accuracy check packs. The pharmacy kept comprehensive records including changes to medication with dates and personnel involved. It kept records of expiry dates and batch numbers for the life of the prescription. They discarded these when the next prescription was dispensed. This ensured that team members could respond appropriately to any recalls. The pharmacy attached tablet descriptions to the packs and kept an electronic record of these. They supplied patient information leaflets each month. The pharmacy sent some prescriptions for compliance packs to an off-site hub in another branch. Team members followed their SOP, which had a robust process for entering data and submitting to the robot, and accuracy checking the packs when received. The pharmacist carried out a full assessment before initiating compliance packs for medicines supply. The pharmacy only supplied medicines in this way if it was the best option for people. It used packs with two or four doses per day depending on the person's requirement. The pharmacy also provided pharmaceutical services to three care homes. It followed SOPs for these, supplying one with medicines on racks and the others in original packs. The team kept copies of medicines administration record (MAR) charts on the computer. Another pharmacy 12 miles away supplied medicines on acute prescriptions to the homes. It faxed the prescriptions to this pharmacy for the pharmacist to undertake clinical assessments. She retained printed copies and records of any advice or information shared with the other pharmacy.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the ‘at-risk’ group and found none. All team members were aware and knew where information was kept.

The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members had attached labels to shelves to highlight these items. They used an assessment form devised internally to identify if people still required to be on these medicines and what level of risk they posed. And they used a tracker to document interventions and advice given. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. They documented this on the PMR. The ACT had identified a prescribing error involving an incorrect dose. She frequently discussed unusual or unexpected doses with the pharmacist. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception and supply of chloramphenicol ophthalmic products. It also followed private PGDs for travel vaccination. The pharmacy empowered team members to assist with the delivery the minor ailments service (eMAS) within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions which they referred to the pharmacist.

The pharmacist attended regular meetings with the GP practice discussing common issues, stock shortages, pharmacy services, future 'prescription for excellence' projects, recent travel vaccination service and topical themes. As she was undertaking independent prescribing training she was at the practice frequently so engaged in informal conversations regularly. They had recently discussed the incidence of Lyme disease which is caused by ticks. The area was popular with visitors for outdoor pursuits. The pharmacist had obtained resources to raise awareness and had stocked up on tick removers. She referred suspected cases of Lyme disease to a GP for early intervention.

The pharmacy had recently introduced the travel vaccination service and all team members had been trained to start conversations and explain the service to people. The pharmacist was familiar with people's requirements before the first appointment. If people required vaccinations that were provided free on the NHS, the pharmacist told them, so they could decide where to have them done. She kept syringes, needles and the anaphylaxis kit out of sight to minimise anxiety in people who were nervous. The pharmacy had a document on the fridge door with vaccine information for reference. The pharmacist asked a colleague to check the products after she had selected them. She also showed them to the person being vaccinated.

The pharmacy offered a blood pressure measure service which was not used frequently. But the pharmacist was measuring blood pressure increasingly often as she was undertaking independent prescribing training in this clinical area. She hoped to extend this to common clinical conditions over time as she believed there was a need locally. The pharmacy provided free condoms on request, a local NHS service. The pharmacist always offered a supply to people she was providing emergency hormonal contraception to. The pharmacist previously undertook all smoking cessation consultations. But recently all team members had been trained and were competent to deliver this service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It scanned Falsified Medicines Directive (FMD) compliant packs for dispensing accuracy and FMD verification. Team members scanned dispensed medicines again at the point of supply, at which time FMD decommissioning took place. All team members had read and signed a SOP. They shared any issues identified with scanning with colleagues in other branches. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It had recently moved diabetic medicines to a separate area to minimise the chance of them being supplied in error. The pharmacy had always stored these seperately, but recently reviewed the location and moved them to a more appropriate location. It

stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. They worked closely with prescribers and the incontinence service to ensure that correct appliances were prescribed and available for the pharmacy to order.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members (or the GP practice on their behalf) contacted all people who had received medicines subject to patient level recalls. They ensured there was adequate stock to replace medication. And they helped some people check their medicine. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works. The pharmacy team members raise concerns when equipment is not working properly. The pharmacy acts in a positive way. The pharmacy team requests and obtains additional equipment as it needs it.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. The pharmacy had recently installed an additional computer in a staff area upstairs. Team members used it for training and administration. They were not disturbed like they were previously when using the consultation room. A team member identified that the labelling system had stopped highlighting new medicines. She reported this recurring problem to the company IT officer who addressed it with the software provider. The issue had now been resolved.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was replaced annually around ‘know your numbers’ day. It had equipment for vaccination including gloves and an anaphylaxis kit which was readily accessible and out of people’s sight. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.